Calendar No. 635

104TH CONGRESS *2d Session*	SENATE	REPORT 104–372

VETERANS' MEDICAL PROGRAMS AMENDMENTS OF 1996

R E P O R T

OF THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

TO ACCOMPANY

S. 1359

SEPTEMBER 26, 1996.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
29–010 WASHINGTON : 1996

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Mr. SIMPSON, from the Committee on Veterans' Affairs, submitted the following

REPORT

[To accompany S. 1359]

The Committee on Veterans' Affairs, to which was referred the bill (S. 1359) to revise certain authorities relating to management and contracting in the provision of health care services and for other purposes, having considered the same, reports favorably thereon with an amendment in the form of a substitute and an amendment to the title, and recommends that the bill as amended do pass.

COMMITTEE AMENDMENTS

The amendments are as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Veterans' Medical Programs Amendments of 1996".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. REFERENCES TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—VETERANS HEALTH ADMINISTRATION

Subtitle A—Administration

SEC. 101. REVISION OF AUTHORITY TO SHARE MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION.

(a) STATEMENT OF PURPOSE.—The text of section 8151 is amended to read as follows:

"It is the purpose of this subchapter to improve the quality of health care provided veterans under this title by authorizing the Secretary to enter into agreements with health-care providers in order to share health-care resources with, and receive health-care resources from, such providers while ensuring no diminution of services to veterans. Among other things, it is intended by these means to strengthen the medical programs at Department facilities located in small cities or rural areas which facilities are remote from major medical centers.".

(b) DEFINITIONS.—Section 8152 is amended—

(1) by striking out paragraphs (1), (2), and (3) and inserting in lieu thereof the following new paragraphs (1) and (2):

"(1) The term 'health-care resource' includes hospital care (as that term is defined in section 1701(5) of this title), any other health-care service, and any health-care support or administrative resource.

"(2) The term 'health-care providers' includes health-care plans and insurers and any organizations, institutions, or other entities or individuals that furnish health-care resources."; and

(2) by redesignating paragraph (4) as paragraph (3).

(c) AUTHORITY TO SECURE HEALTH-CARE RESOURCES.—(1) Section 8153 is amended—

(A) by striking out paragraph (1) of subsection (a) and inserting in lieu thereof the following new paragraph (1):

"(1) The Secretary, when the Secretary determines it to be necessary in order to secure health-care resources which might not otherwise be feasibly available or to utilize effectively health-care resources, may make arrangements, by contract or other form of agreement, for the mutual use, or exchange of use, of health-care resources between Department health-care facilities and non-Department health-care providers. The Secretary may make such arrangements without regard to any law or regulation relating to competitive procedures."; and

(B) by striking out subsection (e).

(2)(A) The section heading of such section is amended to read as follows:

"§ 8153. Sharing of health-care resources".

(B) The table of sections at the beginning of chapter 81 is amended by striking out the item relating to section 8153 and inserting in lieu thereof the following new item:

"8153. Sharing of health-care resources.".

SEC. 102. WAITING PERIOD FOR ADMINISTRATIVE REORGANIZATIONS.

Section 510(b) is amended by striking out "90-day period of continuous session of Congress following" and inserting in lieu thereof "45-day period (30 days of which shall be days during which Congress shall have been in continuous session) beginning on".

SEC. 103. REPEAL OF LIMITATIONS ON CONTRACTS FOR CONVERSION OF PERFORMANCE OF ACTIVITIES OF DEPARTMENT HEALTH-CARE FACILITIES.

Section 8110 is amended by striking out subsection (c).

Subtitle B—Personnel

SEC. 111. REVISION OF ADMINISTRATIVE AUTHORITIES REGARDING RESIDENCIES AND INTERNSHIPS.

(a) COVERED RESIDENTS AND INTERNS.—Section 7406(c) is amended by striking out "Department hospital" each place it appears (other than paragraphs (2)(B) and (4)(C)) and inserting in lieu thereof "Department facility furnishing hospital care or medical services".

(b) CONFORMING AMENDMENTS.—Such section is further amended—

(1) in paragraph (2)(B), by striking out "Department hospital" and inserting in lieu thereof "Department facility";

(2) in paragraph (4), by striking out "participating hospital, including a Department hospital" and inserting in lieu thereof "participating facility, including a Department facility"; and

(3) in paragraph (5), by striking out "hospital" both places it appears and inserting in lieu thereof "facility".

SEC. 112. RENUMERATED OUTSIDE PROFESSIONAL ACTIVITIES BY VETERANS HEALTH ADMINISTRATION PERSONNEL.

(a) AUTHORITY.—Subsection (b) of section 7423 is amended—

(1) by striking out paragraph (1); and

(2) by redesignating paragraphs (2) through (6) as paragraphs (1) through (5), respectively.

(b) CONFORMING AMENDMENT.—Subsection (c) of such section is amended in the matter preceding paragraph (1) by striking out "subsection (b)(6)" and inserting in lieu thereof "subsection (b)(5)".

SEC. 113. AUTHORITY TO WAIVE SPECIAL PAY AGREEMENT REFUND REQUIREMENTS FOR PHYSICIANS AND DENTISTS WHO ENTER INTO RESIDENCY TRAINING PROGRAMS.

Section 7432(b)(2) is amended—

(1) by inserting "(A)" after "(2)"; and

(2) by adding at the end the following:

"(B) The Secretary may suspend the applicability of an agreement under this subchapter in the case of a physician or dentist who enters a residency training program for the period of the participation of the physician or dentist, as the case may be, in the program. The physician or dentist shall not be subject to the refund requirements with respect to the agreement under paragraph (1) during the period of the suspension.".

TITLE II—HEALTH CARE

Subtitle A—Readjustment Counseling

SEC. 201. ORGANIZATION OF THE READJUSTMENT COUNSELING SERVICE IN THE DEPARTMENT OF VETERANS AFFAIRS.

(a) REVISION OF ORGANIZATIONAL STRUCTURE.—(1) The Secretary of Veterans Affairs may not alter or revise the organizational structure or the administrative structure of the organization (known as the Readjustment Counseling Service) with-

in the Veterans Health Administration created to implement the programs established under section 1712A of title 38, United States Code, until—

(A) the Secretary has submitted to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report containing a full and complete statement of the proposed alteration or revision; and

(B) a period of 60 days has elapsed after the date on which the report is received by the committees.

(2) In the computation of the 60-day period under paragraph (1)(B), there shall be excluded any day on which either House of Congress is not in session because of an adjournment of more than 3 calendar days to a day certain.

(b) BUDGET INFORMATION RELATING TO THE SERVICE.—Each budget submitted to Congress by the President under section 1105 of title 31, United States Code, shall set forth the amount requested in the budget for the operation of the organization referred to in subsection (a)(1) in the fiscal year covered by the budget and shall set forth separately the amount requested for administrative oversight of the activities of the organization.

SEC. 202. EXPANSION OF ELIGIBILITY FOR READJUSTMENT COUNSELING AND CERTAIN RELATED COUNSELING SERVICES.

(a) READJUSTMENT COUNSELING.—(1) Subsection (a) of section 1712A is amended to read as follows:

"(a)(1)(A) Upon the request of any veteran referred to in subparagraph (B) of this paragraph, the Secretary shall furnish counseling to the veteran to assist the veteran in readjusting to civilian life.

"(B) Subparagraph (A) applies to the following veterans:

"(i) Any veteran who served on active duty in a theater of combat operations (as determined by the Secretary in consultation with the Secretary of Defense) during the Vietnam era.

"(ii) Any veteran who served on active duty during the Vietnam era if the veteran seeks such counseling before January 1, 2000.

"(iii) Any veteran referred to in clause (ii) of this subparagraph if the veteran is furnished counseling under this subsection before the date referred to in that clause.

"(iv) Any veteran who served on active military, naval, or air service in a theater of combat operations (as so determined) during a period of war, or in any other area during a period in which hostilities (as defined in subparagraph (D) of this paragraph) occurred in such area.

"(C) Upon the request of any veteran other than a veteran covered by subparagraph (A) of this paragraph, the Secretary may furnish counseling to the veteran to assist the veteran in readjusting to civilian life.

"(D) For the purposes of subparagraph (B) of this paragraph, the term 'hostilities' means an armed conflict in which the members of the Armed Forces are subjected to danger comparable to the danger to which members of the Armed Forces have been subjected in combat with enemy armed forces during a period of war, as determined by the Secretary in consultation with the Secretary of Defense.

"(2) The counseling referred to in paragraph (1) of this subsection shall include a general mental and psychological assessment of a covered veteran to ascertain whether such veteran has mental or psychological problems associated with readjustment to civilian life.".

(2) Subsection (c) of such section is repealed.

(b) OTHER COUNSELING.—Such section is further amended by inserting after subsection (b) the following new subsection (c):

"(c)(1) The Secretary shall provide the counseling services described in section 1701(6)(B)(ii) of this title to the surviving parents, spouse, and children of any member of the Armed Forces who dies—

"(A) in a theater of combat operations (as determined by the Secretary in consultation with the Secretary of Defense) while on active military, naval, or air service during a period of war;

"(B) in an area in which hostilities (as defined in subsection (a)(1)(D) of this section) are occurring while on such service during such hostilities;

"(C) as a result of a disease, injury, or condition incurred while on such service in a theater of combat operations (as so determined)

"(2) The Secretary may provide the counseling services referred to in paragraph (1) of this subsection to the surviving parents, spouse, and children of any member of the Armed Forces who dies while serving on active duty or from a condition (as determined by the Secretary) incurred in or aggravated by such service.".

(c) AUTHORITY TO CONTRACT FOR COUNSELING SERVICES.—Subsection (e) of such section is amended by striking out "subsections (a) and (b)" each place it appears and inserting in lieu thereof "subsections (a), (b), and (c)".

SEC. 203. ADVISORY COMMITTEE ON THE READJUSTMENT OF VETERANS.

(a) IN GENERAL.—(1) Subchapter III of chapter 5 is amended by inserting after section 544 the following:

"§545. Advisory Committee on the Readjustment of Veterans

"(a)(1) There is in the Department the Advisory Committee on the Readjustment of Veterans (hereinafter in this section referred to as the 'Committee').

"(2) The Committee shall consist of not more than 18 members appointed by the Secretary from among individuals who—

"(A) have demonstrated significant civic or professional achievement; and

"(B) have experience with the provision of veterans benefits and services by the Department.

"(3) The Secretary shall seek to ensure that members appointed to the Committee include individuals from a wide variety of geographic areas and ethnic backgrounds, individuals from veterans service organizations, individuals with combat experience, and women.

"(4) The Secretary shall determine the terms of service and pay and allowances of the members of the Committee, except that a term of service may not exceed 2 years. The Secretary may reappoint any member for additional terms of service.

"(b)(1) The Secretary shall, on a regular basis, consult with and seek the advice of the Committee with respect to the provision by the Department of benefits and services to veterans in order to assist veterans in the readjustment to civilian life.

"(2)(A) In providing advice to the Secretary under this subsection, the Committee shall—

"(i) assemble and review information relating to the needs of veterans in readjusting to civilian life;

"(ii) provide information relating to the nature and character of psychological problems arising from service in the Armed Forces;

"(iii) provide an on-going assessment of the effectiveness of the policies, organizational structures, and services of the Department in assisting veterans in readjusting to civilian life; and

"(iv) provide on-going advice on the most appropriate means of responding to the readjustment needs of veterans in the future.

"(B) In carrying out its duties under subparagraph (A), the Committee shall take into special account the needs of veterans who have served in a theater of combat operations.

"(c)(1) Not later than March 31 of each year, the Committee shall submit to the Secretary a report on the programs and activities of the Department that relate to the readjustment of veterans to civilian life. Each such report shall include—

"(A) an assessment of the needs of veterans with respect to readjustment to civilian life;

"(B) a review of the programs and activities of the Department designed to meet such needs; and

"(C) such recommendations (including recommendations for administrative and legislative action) as the Committee considers appropriate.

"(2) Not later than 90 days after the receipt of a report under paragraph (1), the Secretary shall transmit to the Committees on Veterans' Affairs of the Senate and House of Representatives a copy of the report, together with any comments and recommendations concerning the report that the Secretary considers appropriate.

"(3) The Committee may also submit to the Secretary such other reports and recommendations as the Committee considers appropriate.

"(4) The Secretary shall submit with each annual report submitted to the Congress pursuant to section 529 of this title a summary of all reports and recommendations of the Committee submitted to the Secretary since the previous annual report of the Secretary submitted pursuant to that section.

"(d)(1) Except as provided in paragraph (2), the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the activities of the Committee under this section.

"(2) Section 14 of such Act shall not apply to the Committee.".

(2) The table of sections at the beginning of chapter 5 is amended by inserting after the item relating to section 544 the following:

"545. Advisory Committee on the Readjustment of Veterans.".

(b) ORIGINAL MEMBERS.—(1) Notwithstanding subsection (a)(2) of section 545 of title 38, United States Code (as added by subsection (a)), the members of the Advi-

sory Committee on the Readjustment of Vietnam and Other War Veterans on the date of the enactment of this Act shall be the original members of the advisory committee recognized under such section.

(2) The original members shall so serve until the Secretary of Veterans Affairs carries out appointments under such subsection (a)(2). The Secretary shall carry out such appointments as soon after such date as is practicable. The Secretary may make such appointments from among such original members.

SEC. 204. REPORT ON COLLOCATION OF VET CENTERS AND DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINICS.

(a) REQUIREMENT.—(1) The Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the feasibility and desirability of the collocation of Vet Centers and outpatient clinics (including rural mobile clinics) of the Department of Veterans Affairs as current leases for such centers and clinics expire.

(2) The Secretary shall submit the report not later than 6 months after the date of the enactment of this Act.

(b) COVERED MATTERS.—The report under this section shall include an assessment of the following:

(1) The results of any collocation of Vet Centers and outpatient clinics carried out by the Secretary before the date of the enactment of this Act, including the effects of such collocation on the quality of care provided at such centers and clinics.

(2) The effect of such collocation on the capacity of such centers and clinics to carry out their primary mission.

(3) The extent to which such collocation will impair the operational independence or administrative integrity of such centers and clinics.

(4) The feasibility of combining the services provided by such centers and clinics in the course of such collocation.

(5) The advisability of the collocation of centers and clinics of significantly different size.

(6) The effect of the locations (including urban and rural locations) of the centers and clinics on the feasibility and desirability of such collocation.

(7) The amount of any costs savings to be achieved by Department as a result of such collocation.

(8) Any other matters that the Secretary determines appropriate.

SEC. 205. REPORT ON PROVISION OF LIMITED HEALTH CARE SERVICES AT READJUSTMENT COUNSELING CENTERS.

(a) REPORT.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the feasibility and desirability of providing a limited battery of health care services (including ambulatory services and health care screening services) to veterans at Department of Veterans Affairs readjustment counseling centers.

(b) REPORT ELEMENTS.—The report under subsection (a) shall include a discussion of the following:

(1) The effect on the advisability of providing health care services at readjustment counseling centers of the geographic location of such centers, including the urban location and rural location of such centers and the proximity of such centers to Department of Veterans Affairs medical facilities.

(2) The effect on the advisability of providing such services at such centers of the type and level of services to be provided, and the demographic characteristics (including age, socio-economic status, ethnicity, and sex) of veterans likely to be provided the services.

(3) The effect of providing such services at such centers on the readjustment counseling center program in general and on the efficiency and autonomy of the clinical and administrative operations of the readjustment counseling centers in particular.

(4) Any other matters that the Secretary considers appropriate.

Subtitle B—Other Provisions

SEC. 211. PAYMENT TO STATES OF PER DIEM FOR VETERANS RECEIVING ADULT DAY HEALTH CARE.

(a) PAYMENT OF PER DIEM FOR VETERANS RECEIVING ADULT DAY CARE.—Section 1741 is amended—

(1) by inserting "(1)" after "(a)";

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively; and

(3) by adding at the end the following new paragraph (2):

"(2) The Secretary may pay each State per diem at a rate determined by the Secretary for each veteran receiving adult day health care in a State home, if such veteran is eligible for such care under laws administered by the Secretary.".

(b) ASSISTANCE TO STATES FOR CONSTRUCTION OF ADULT DAY CARE FACILITIES.—(1) Section 8131(3) is amended by inserting "adult day health," before "or hospital care".

(2) Section 8132 is amended by inserting "adult day health," before "or hospital care".

(3) Section 8135(b) is amended—

(A) in paragraph (2)(C), by inserting "or adult day health care facilities" after "domiciliary beds"; and

(B) in paragraph (3)(A), by inserting "or construction (other than new construction) of adult day health care buildings" before the semicolon.

SEC. 212. EXPANDED HEALTH CARE SHARING AGREEMENT AUTHORITY.

Section 204 of the Veterans Health Care Act of 1992 (Public Law 102–585; 106 Stat. 4950; 38 U.S.C. 8111 note) is amended by striking out "October 1, 1996" and inserting in lieu thereof "December 31, 1998".

SEC. 213. EVALUATION OF HEALTH STATUS OF SPOUSES AND CHILDREN OF PERSIAN GULF WAR VETERANS.

Section 107(b) of the Persian Gulf War Veterans' Benefits Act (title I of Public Law 103–446; 108 Stat. 4652; 38 U.S.C. 1117 note) is amended by striking out "September 30, 1996" and inserting in lieu thereof "December 31, 1998".

SEC. 214. TRANSMITTAL OF REPORTS OF SPECIAL COMMITTEE FOR THE SERIOUSLY MENTALLY ILL VETERAN.

(a) TRANSMITTAL.—Not later than 60 days after the submittal to the Under Secretary for Health of the Department of Veterans Affairs of a report referred to in subsection (b), the Secretary of Veterans Affairs shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a copy of the report, together with the comments of the Under Secretary for Health on the report.

(b) COVERED REPORTS.—Subsection (a) applies to any report submitted to the Under Secretary for Health by the Special Committee for the Seriously Mentally Ill Veteran as in existence on July 1, 1996.

TITLE III—HEALTH CARE RESEARCH

SEC. 301. MENTAL ILLNESS RESEARCH, EDUCATION, AND CLINICAL CENTERS.

(a) IN GENERAL.—Subchapter II of chapter 73 is amended by adding at the end the following:

"§ 7319. Mental illness research, education, and clinical centers

"(a) The purpose of this section is to improve the provision of health-care services and related counseling services to eligible veterans suffering from mental illness, especially mental illness related to service-related conditions, through research (including research on improving mental health service facilities of the Department and on improving the delivery of mental health services by the Department), education and training of personnel, and the development of improved models and systems for the furnishing of mental health services by the Department.

"(b)(1) In order to carry out the purpose of this section, the Secretary, upon the recommendation of the Under Secretary for Health and pursuant to the provisions of this subsection, shall—

"(A) designate not more than five health-care facilities of the Department as the locations for a center of research on mental health services, on the use by the Department of specific models for furnishing such services, on education and training, and on the development and implementation of innovative clinical activities and systems of care with respect to the delivery of such services by the Department; and

"(B) subject to the appropriation of funds for such purpose, establish and operate such centers at such locations in accordance with this section.

"(2) The Secretary shall designate at least one facility under paragraph (1) not later than January 1, 1997.

"(3) The Secretary shall, upon the recommendation of the Under Secretary for Health, ensure that the facilities designated for centers under paragraph (1) are located in various geographic regions.

"(4) The Secretary may not designate any health-care facility as a location for a center under paragraph (1) unless—

"(A) the peer review panel established under paragraph (5) has determined under that paragraph that the proposal submitted by such facility as a location for a new center under this subsection is among those proposals which have met the highest competitive standards of scientific and clinical merit; and

"(B) the Secretary, upon the recommendation of the Under Secretary for Health, determines that the facility has developed (or may reasonably be anticipated to develop)—

"(i) an arrangement with an accredited medical school which provides education and training in psychiatry and with which the facility is affiliated under which arrangement residents receive education and training in psychiatry through regular rotation through the facility so as to provide such residents with training in the diagnosis and treatment of mental illness;

"(ii) an arrangement with an accredited graduate program of psychology under which arrangement students receive education and training in clinical, counseling, or professional psychology through regular rotation through the facility so as to provide such students with training in the diagnosis and treatment of mental illness;

"(iii) an arrangement under which nursing, social work, counseling, or allied health personnel receive training and education in mental health care through regular rotation through the facility;

"(iv) the ability to attract scientists who have demonstrated creativity and achievement in research—

"(I) into the evaluation of innovative approaches to the design of mental health services; or

"(II) into the causes, prevention, and treatment of mental illness;

"(v) a policymaking advisory committee composed of appropriate mental health-care and research personnel of the facility and of the affiliated school or schools to advise the directors of the facility and the center on policy matters pertaining to the activities of the center during the period of the operation of the center; and

"(vi) the capability to evaluate effectively the activities of the center, including the evaluation of specific efforts to improve the quality and effectiveness of mental health services provided by the Department at or through individual facilities.

"(5)(A) In order to provide advice to assist the Under Secretary for Health and the Secretary to carry out their responsibilities under this section, the official within the Central Office of the Veterans Health Administration responsible for mental health and behavioral sciences matters shall establish a panel to assess the scientific and clinical merit of proposals that are submitted to the Secretary for the establishment of new centers under this subsection.

"(B) The membership of the panel shall consist of experts in the fields of mental health research, education and training, and clinical care. Members of the panel shall serve as consultants to the Department for a period of no longer than six months.

"(C) The panel shall review each proposal submitted to the panel by the official referred to in subparagraph (A) and shall submit its views on the relative scientific and clinical merit of each such proposal to that official.

"(D) The panel shall not be subject to the provisions of the Federal Advisory Committee Act (5 U.S.C. App.).

"(c) Clinical and scientific investigation activities at each center established under subsection (b)(1) may compete for the award of funding from amounts appropriated for the Department of Veterans Affairs medical and prosthetics research account and shall receive priority in the award of funding from such account insofar as funds are awarded to projects and activities relating to mental illness.

"(d) The Under Secretary for Health shall ensure that at least three centers designated under subsection (b)(1)(A) emphasize research into means of improving the quality of care for veterans suffering from mental illness through the development of community-based alternatives to institutional treatment for such illness.

"(e) The Under Secretary for Health shall ensure that useful information produced by the research, education and training, and clinical activities of the centers established under subsection (b)(1) is disseminated throughout the Veterans Health Administration through publications and through programs of continuing medical and

related education provided through regional medical education centers under subchapter VI of chapter 74 of this title and through other means.

"(f) The official within the Central Office of the Veterans Health Administration responsible for mental health and behavioral sciences matters shall be responsible for supervising the operation of the centers established pursuant to subsection (b)(1).

"(g)(1) There are authorized to be appropriated for the Department of Veterans Affairs for the basic support of the research and education and training activities of the centers established pursuant to subsection (b)(1) the following:

"(A) $3,125,000 for fiscal year 1997.

"(B) $6,250,000 for each of fiscal years 1998 through 2000.

"(2) In addition to the funds available under the authorization of appropriations in paragraph (1), the Under Secretary for Health shall allocate to such centers from other funds appropriated generally for the Department of Veterans Affairs medical care account and the Department of Veterans Affairs medical and prosthetics research account such amounts as the Under Secretary for Health determines appropriate in order to carry out the purposes of this section.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by adding at the end of the matter relating to subchapter II the following:

"7319. Mental illness research, education, and clinical centers.".

(c) REPORTS.—Not later than February 1 of each of 1997, 1998, and 1999, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the status and activities during the previous fiscal year of the mental illness, research, education, and clinical centers established pursuant to section 7319 of title 38, United States Code (as added by subsection (a)). Each such report shall contain the following:

(1) A description of—

(A) the activities carried out at each center and the funding provided for such activities;

(B) the advances made at each center in research, education and training, and clinical activities relating to mental illness in veterans; and

(C) the actions taken by the Under Secretary for Health pursuant to subsection (d) of such section (as so added) to disseminate useful information derived from such activities throughout the Veterans Health Administration.

(2) The Secretary's evaluations of the effectiveness of the centers in fulfilling the purposes of the centers.

SEC 302. RESEARCH CORPORATIONS.

(a) RENEWAL OF AUTHORITY.—Section 7368 is amended by striking out "December 31, 1992" and inserting in lieu thereof "December 31, 2000".

(b) CLARIFICATION OF TAX-EXEMPT STATUS.—(1) Section 7361(b) is amended by striking out "section 501(c)(3) of".

(2) Section 7363(c) is amended by striking out "section 501(c)(3) of".

(c) REVISED REPORTING REQUIREMENT.—Subsection (d) of section 7366 is amended to read as follows:

"(d) The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an annual report on the corporations established under this subchapter. The report shall set forth the following information:

"(1) The location of each corporation.

"(2) The amount received by each corporation during the previous year, including—

"(A) the total amount received;

"(B) the amount received from governmental entities;

"(C) the amount received from entities the income of which is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986 (26 U.S.C. 501(c)(3));

"(D) the amount received from all other sources; and

"(E) if the amount received from a source referred to in subparagraph (D) exceeded $25,000, information that identifies the source.

"(3) The amount expended by each corporation during the year, including—

"(A) the amount expended for salary for research staff and for salary for support staff;

"(B) the amount expended for other direct support of research; and

"(C) if the amount expended with respect to any source exceeded $10,000, information that identifies the source.".

TITLE IV—HOSPICE CARE SERVICES

SEC. 401. SHORT TITLE.

This title may be cited as the "Veterans' Hospice Care Services Act of 1996".

SEC. 402. PROGRAMS FOR FURNISHING HOSPICE CARE TO VETERANS.

(a) ESTABLISHMENT OF PROGRAMS.—Chapter 17 of title 38, United States Code, is amended by adding at the end the following:

"Subchapter VII—Hospice Care Pilot Program; Hospice Care Services

"§ 1761. Definitions

"For the purposes of this subchapter—

"(1) The term "terminally ill veteran" means any veteran—

"(A) who is (i) entitled to receive hospital care in a medical facility of the Department under section 1710(a)(1) of this title, (ii) eligible for hospital or nursing home care in such a facility and receiving such care, (iii) receiving care in a State home facility for which care the Secretary is paying per diem under section 1741 of this title, or (iv) transferred to a non-Department nursing home for nursing home care under section 1720 of this title and receiving such care; and

"(B) who has a medical prognosis (as certified by a Department physician) of a life expectancy of six months or less.

"(2) The term 'hospice care services' means—

"(A) the care, items, and services referred to in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)); and

"(B) personal care services.

"(3) The term "hospice program" means any program that satisfies the requirements of section 1861(dd)(2) of the Social Security Act (42 U.S.C. 1395x(dd)(2)).

"(4) The term "medical facility of the Department" means a facility referred to in section 1701(3)(A) of this title.

"(5) The term 'non-Department facility' means a facility (other than a medical facility of the Department) at which care to terminally ill veterans is furnished, regardless of whether such care is furnished pursuant to a contract, agreement, or other arrangement referred to in section 1762(b)(1)(D) of this title.

"(6) The term 'personal care services' means any care or service furnished to a person that is necessary to maintain a person's health and safety within the home or nursing home of the person, including care or services related to dressing and personal hygiene, feeding and nutrition, and environmental support.

"§ 1762. Hospice care: pilot program requirements

"(a)(1) During the period beginning on October 1, 1996, and ending on December 31, 2001, the Secretary shall conduct a pilot program in order—

"(A) to assess the desirability of furnishing hospice care services to terminally ill veterans; and

"(B) to determine the most effective and efficient means of furnishing such services to such veterans.

"(2) The Secretary shall conduct the pilot program in accordance with this section.

"(b)(1) Under the pilot program, the Secretary shall—

"(A) designate not less than 15 nor more than 30 medical facilities of the Department at or through which to conduct hospice care services demonstration projects;

"(B) designate the means by which hospice care services shall be provided to terminally ill veterans under each demonstration project pursuant to subsection (c);

"(C) allocate such personnel and other resources of the Department as the Secretary considers necessary to ensure that services are provided to terminally ill veterans by the designated means under each demonstration project; and

"(D) enter into any contract, agreement, or other arrangement that the Secretary considers necessary to ensure the provision of such services by the designated means under each such project.

"(2) In carrying out the responsibilities referred to in paragraph (1) the Secretary shall take into account the need to provide for and conduct the demonstration projects so as to provide the Secretary with such information as is necessary for the Secretary to evaluate and assess the furnishing of hospice care services to terminally ill veterans by a variety of means and in a variety of circumstances.

"(3) In carrying out the requirement described in paragraph (2), the Secretary shall, to the maximum extent feasible, ensure that—

"(A) the medical facilities of the Department selected to conduct demonstration projects under the pilot program include facilities located in urban areas of the United States and rural areas of the United States;

"(B) the full range of affiliations between medical facilities of the Department and medical schools is represented by the facilities selected to conduct demonstration projects under the pilot program, including no affiliation, minimal affiliation, and extensive affiliation;

"(C) such facilities vary in the number of beds that they operate and maintain; and

"(D) the demonstration projects are located or conducted in accordance with any other criteria or standards that the Secretary considers relevant or necessary to furnish and to evaluate and assess fully the furnishing of hospice care services to terminally ill veterans.

"(c)(1) Subject to paragraph (2), hospice care to terminally ill veterans shall be furnished under a demonstration project by one or more of the following means designated by the Secretary:

"(A) By the personnel of a medical facility of the Department providing hospice care services pursuant to a hospice program established by the Secretary at that facility.

"(B) By a hospice program providing hospice care services under a contract with that program and pursuant to which contract any necessary inpatient services are provided at a medical facility of the Department.

"(C) By a hospice program providing hospice care services under a contract with that program and pursuant to which contract any necessary inpatient services are provided at a non-Department medical facility.

"(2)(A) The Secretary shall provide that—

"(i) care is furnished by the means described in paragraph (1)(A) at not less than five medical facilities of the Department; and

"(ii) care is furnished by the means described in subparagraphs (B) and (C) of paragraph (1) in connection with not less than five such facilities for each such means.

"(B) The Secretary shall provide in any contract under subparagraph (B) or (C) of paragraph (1) that inpatient care may be provided to terminally ill veterans at a medical facility other than that designated in the contract if the provision of such care at such other facility is necessary under the circumstances.

"(d)(1) Except as provided in paragraph (2), the amount paid to a hospice program for care furnished pursuant to subparagraph (B) or (C) of subsection (c)(1) may not exceed the amount that would be paid to that program for such care under section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) if such care were hospice care for which payment would be made under part A of title XVIII of such Act.

"(2) The Secretary may pay an amount in excess of the amount referred to in paragraph (1) (or furnish services whose value, together with any payment by the Secretary, exceeds such amount) to a hospice program for furnishing care to a terminally ill veteran pursuant to subparagraph (B) or (C) of subsection (c)(1) if the Secretary determines, on a case-by-case basis, that—

"(A) the furnishing of such care to the veteran is necessary and appropriate; and

"(B) the amount that would be paid to that program under section 1814(i) of the Social Security Act would not compensate the program for the cost of furnishing such care.

"§ 1763. Care for terminally ill veterans

"(a) During the period referred to in section 1762(a)(1) of this title, the Secretary shall designate not less than 10 medical facilities of the Department at which hospital care is being furnished to terminally ill veterans in order to furnish the care referred to in subsection (b)(1).

"(b)(1) Palliative care to terminally ill veterans shall be furnished at the facilities referred to in subsection (a) by one of the following means designated by the Secretary:

"(A) By personnel of the Department providing one or more hospice care services to such veterans at or through medical facilities of the Department.

"(B) By personnel of the Department monitoring the furnishing of one or more of such services to such veterans at or through non-Department facilities.

"(2) The Secretary shall furnish care by the means referred to in each of subparagraphs (A) and (B) of paragraph (1) at not less than five medical facilities designated under subsection (a).

"§ 1764. Information relating to hospice care services

"The Secretary shall ensure to the extent practicable that terminally ill veterans who have been informed of their medical prognosis receive information relating to the eligibility, if any, of such veterans for hospice care and services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

"§ 1765. Evaluation and reports

"(a) Not later than September 30, 1997, and on an annual basis thereafter until October 1, 2002, the Secretary shall submit a written report to the Committees on Veterans' Affairs of the Senate and House of Representatives relating to the conduct of the pilot program under section 1762 of this title and the furnishing of hospice care services under section 1763 of this title. Each report shall include the following information:

"(1) The location of the sites of the demonstration projects provided for under the pilot program.

"(2) The location of the medical facilities of the Department at or through which hospice care services are being furnished under section 1763 of this title.

"(3) The means by which care to terminally ill veterans is being furnished under each such project and at or through each such facility.

"(4) The number of veterans being furnished such care under each such project and at or through each such facility.

"(5) An assessment by the Secretary of any difficulties in furnishing such care and the actions taken to resolve such difficulties.

"(b) Not later than August 1, 2000, the Secretary shall submit to the committees referred to in subsection (a) a report containing an evaluation and assessment by the Under Secretary for Health of the hospice care pilot program under section 1762 of this title and the furnishing of hospice care services under section 1763 of this title. The report shall contain such information (and shall be presented in such form) as will enable the committees to evaluate fully the desirability of furnishing hospice care services to terminally ill veterans.

"(c) The report under subsection (b) shall include the following:

"(1) A description and summary of the pilot program.

"(2) With respect to each demonstration project conducted under the pilot program—

"(A) a description and summary of the project;

"(B) a description of the facility conducting the demonstration project and a discussion of how such facility was selected in accordance with the criteria set out in, or prescribed by the Secretary pursuant to, subparagraphs (A) through (D) of section 1762(b)(3) of this title;

"(C) the means by which hospice care services care are being furnished to terminally ill veterans under the demonstration project;

"(D) the personnel used to furnish such services under the demonstration project;

"(E) a detailed factual analysis with respect to the furnishing of such services, including (i) the number of veterans being furnished such services, (ii) the number, if any, of inpatient admissions for each veteran being furnished such services and the length of stay for each such admission, (iii) the number, if any, of outpatient visits for each such veteran, and (iv) the number, if any, of home-care visits provided to each such veteran;

"(F) the direct costs, if any, incurred by terminally ill veterans, the members of the families of such veterans, and other individuals in close relationships with such veterans in connection with the participation of veterans in the demonstration project;

"(G) the costs incurred by the Department in conducting the demonstration project, including an analysis of the costs, if any, of the demonstration project that are attributable to (i) furnishing such services in facilities of the Department, (ii) furnishing such services in non-Department facilities, and (iii) administering the furnishing of such services; and

"(H) the unreimbursed costs, if any, incurred by any other entity in furnishing services to terminally ill veterans under the project pursuant to section 1762(c)(1)(C) of this title.

"(3) An analysis of the level of the following persons' satisfaction with the services furnished to terminally ill veterans under each demonstration project:

"(A) Terminally ill veterans who receive such services, members of the families of such veterans, and other individuals in close relationships with such veterans.

"(B) Personnel of the Department responsible for furnishing such services under the project.

"(C) Personnel of non-Department facilities responsible for furnishing such services under the project.

"(4) A description and summary of the means of furnishing hospice care services at or through each medical facility of the Department designated under section 1763(a) of this title.

"(5) With respect to each such means, the information referred to in paragraphs (2) and (3).

"(6) A comparative analysis by the Under Secretary for Health of the services furnished to terminally ill veterans under the various demonstration projects referred to in section 1762 of this title and at or through the designated facilities referred to in section 1763 of this title, with an emphasis in such analysis on a comparison relating to—

"(A) the management of pain and health symptoms of terminally ill veterans by such projects and facilities;

"(B) the number of inpatient admissions of such veterans and the length of inpatient stays for such admissions under such projects and facilities;

"(C) the number and type of medical procedures employed with respect to such veterans by such projects and facilities; and

"(D) the effectiveness of such projects and facilities in providing care to such veterans at the homes of such veterans or in nursing homes.

"(7) An assessment by the Under Secretary for Health of the desirability of furnishing hospice care services by various means to terminally ill veterans, including an assessment by the Director of the optimal means of furnishing such services to such veterans.

"(8) Any recommendations for additional legislation regarding the furnishing of care to terminally ill veterans that the Secretary considers appropriate.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by adding at the end the following:

"Subchapter VII—Hospice Care Pilot Program; Hospice Care Services

"1761. Definitions.
"1762. Hospice care: pilot program requirements.
"1763. Care for terminally ill veterans.
"1764. Information relating to hospice care services.
"1765. Evaluation and reports.".

(c) AUTHORITY TO CARRY OUT OTHER HOSPICE CARE PROGRAMS.—The amendments made by subsection (a) may not be construed as terminating the authority of the Secretary of Veterans Affairs to provide hospice care services to terminally ill veterans under any program in addition to the programs required under the provisions added by such amendments.

(d) AUTHORIZATION OF APPROPRIATIONS.—Funds are authorized to be appropriated for the Department of Veterans Affairs for the purposes of carrying out the evaluation of the hospice care pilot programs under section 1765 of title 38, United States Code (as added by subsection (a)), as follows:

(1) For fiscal year 1997, $1,200,000.
(2) For fiscal year 1998, $2,500,000.
(3) For fiscal year 1999, $2,200,000.
(4) For fiscal year 2000, $100,000.

TITLE V—MAMMOGRAPHY STANDARDS

SEC. 501. SHORT TITLE.

This title may be cited as the "Women Veterans' Mammography Quality Standards Act".

SEC. 502. MAMMOGRAPHY QUALITY STANDARDS.

(a) PERFORMANCE OF MAMMOGRAMS.—Mammograms may not be performed at a Department of Veterans Affairs facility unless that facility is accredited for that purpose by a private nonprofit organization designated by the Secretary of Veterans Affairs. The organization designated by the Secretary under this subsection shall meet the standards for accrediting bodies established by the Secretary of Health and Human Services under section 354(e) of the Public Health Service Act (42 U.S.C. 263b(e)).

(b) QUALITY STANDARDS.—(1) Not later than 120 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall prescribe quality assurance and quality control standards relating to the performance and interpretation of mammograms and use of mammogram equipment and facilities by personnel of the Department of Veterans Affairs. Such standards shall be no less stringent than the

standards prescribed by the Secretary of Health and Human Services under section 354(f) of the Public Health Service Act.

(2) The Secretary of Veterans Affairs shall prescribe standards under this subsection in consultation with the Secretary of Health and Human Services.

(c) INSPECTION OF DEPARTMENT EQUIPMENT.—(1) The Secretary of Veterans Affairs shall, on an annual basis, inspect the equipment and facilities utilized by and in Department of Veterans Affairs health-care facilities for the performance of mammograms in order to ensure the compliance of such equipment and facilities with the standards prescribed under subsection (b). Such inspection shall be carried out in a manner consistent with the inspection of certified facilities by the Secretary of Health and Human Services under section 354(g) of the Public Health Service Act.

(2) The Secretary of Veterans Affairs may not delegate the responsibility of such Secretary under paragraph (1) to a State agency.

(d) APPLICATION OF STANDARDS TO CONTRACT PROVIDERS.—The Secretary of Veterans Affairs shall ensure that mammograms performed for the Department of Veterans Affairs under contract with any non-Department facility or provider conform to the quality standards prescribed by the Secretary of Health and Human Services under section 354 of the Public Health Service Act.

(e) REPORT.—(1) The Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the quality standards prescribed by the Secretary under subsection (b)(1).

(2) The Secretary shall submit the report not later than 180 days after the date on which the Secretary prescribes such regulations.

(f) DEFINITION.—In this section, the term "mammogram" shall have the meaning given such term in section 354(a)(5) of the Public Health Service Act (42 U.S.C. 263b(a)).

Amend the title to read as follows:

"To amend title 38, United States Code, to improve the provision of health care services to veterans by the Department of Veterans Affairs, and for other purposes.".

INTRODUCTION

On October 24, 1995, the Chairman of the Committee, Senator Alan K. Simpson, introduced S. 1359, which would have revised certain authorities relating to management and contracting in the provision of health care services by the Department of Veterans Affairs (VA).

On January 30, 1995, Senator Kent Conrad introduced S. 293 with the cosponsorship of Senators Thomas A. Daschle, Byron L. Dorgan, and Claiborne Pell, and Committee members Daniel K. Akaka, James M. Jeffords, and Bob Graham, which would have authorized the payment to States of per diem for veterans receiving adult day health care in State facilities.

On February 14, 1995, Senator Akaka introduced S. 403 with the cosponsorship of Senator Daschle, Senator Wellstone, Senator Daniel K. Inouye, and Senator Jeffords, which would have modified authorities relating to the organization and administration of VA's Readjustment Counseling Service, and would have modified eligibility for readjustment and related counseling services.

On February 15, 1995, the Ranking Minority Member of the Committee, Senator John D. Rockefeller IV, introduced S. 425 with the cosponsorship of Senator Akaka, Committee member Ben Nighthorse Campbell, Senator Dorgan, and Senator Wellstone, which would have required the establishment in VA of mental illness research, education, and clinical centers.

On March 14, 1995, Senator Rockefeller introduced S. 548, which would have required VA to adopt quality standards with respect to the provision of mammography services.

On March 24, 1995, Senator Rockefeller introduced S. 612 with the cosponsorship of Senator Daschle and Committee members Bob Graham and Frank H. Murkowski, which would have established in VA a pilot program to provide hospice care services to terminally ill veterans.

On March 29, 1995, Committee member Campbell introduced S. 644 with the cosponsorship of Senator Hank Brown and Committee member Akaka, which would have reauthorized the establishment of research corporations in the VA's Veterans Health Administration (VHA).

On May 13, 1996, Senator Simpson introduced several bills at the request of the administration, including S. 1750, which would have modified VA's disbursement agreement authority so that compensation to medical residents and interns serving in any VA health care facility would be included within that authority; S. 1752, which would have exempted full-time registered nurses, physician assistants, and expanded-function dental auxiliaries from restrictions on remunerated outside professional activities; and S. 1753, which would have expanded the VA's authority to suspend special pay agreements so that such agreements might be waived with respect to physicians and dentists who enter residency training programs.

On May 11, 1995, the Committee on Veterans' Affairs held a hearing on a proposal to reorganize VHA, and on potential modifications to the "waiting period" requirement of 38 U.S.C. §510 which later became a portion of S. 1359, as introduced. The Committee received testimony from the Honorable Kenneth W. Kizer, M.D., M.P.H., Under Secretary for Health, Department of Veterans Affairs, accompanied by Thomas L. Garthwaite, M.D., Deputy Under Secretary for Health; Jule Moravec, Ph.D., Associate Chief Medical Director for Operations; Kenneth J. Clark, Director, West Los Angeles VA Medical Center, and Chair, Board of Directors, Southern California and Nevada Directors Association; and Robert E. Coy, Deputy General Counsel. Testimony was also submitted for the hearing record by the Air Force Sergeants Association, The American Legion, Vietnam Veterans of America, Nurses Organization of Veterans Affairs, National Association of VA Physicians and Dentists, and the American Psychological Association.

On October 25, 1995, the Committee held a hearing on, among other things, S. 1359, S. 293, S. 403, S. 425, S. 548, S. 612, and S. 644. The Committee received testimony from the Honorable Kenneth W. Kizer, M.D., M.P.H., Under Secretary for Health, Department of Veterans Affairs, accompanied by the Honorable Mary Lou Keener, General Counsel, Department of Veterans Affairs. Testimony was also received from The American Legion, Veterans of Foreign Wars, Disabled American Veterans, and Paralyzed Veterans of America.

On May 23, 1996, the Committee held a hearing on, among other things, S. 1750, S. 1752, and S. 1753. Testimony was received from the Honorable Frank Q. Nebeker, Chief Judge, Court of Veterans Appeals; the Honorable Charles L. Cragin, Chairman, Board of Veterans' Appeals, Department of Veterans Affairs, accompanied by Jule D. Moravec, Ph.D., Chief Network Officer, Veterans Health Administration; Mr. J. Gary Hickman, Director, Compensation and

Pension Service, Veterans Benefits Administration; Mr. Keith R. Pedigo, Director, Loan Guaranty Service, Veterans Benefits Administration; and Mr. Robert E. Coy, Deputy General Counsel, Department of Veterans Affairs. Testimony was also received from representatives of The American Legion, Veterans of Foreign Wars, Disabled American Veterans, Paralyzed Veterans of America, Vietnam Veterans of America, Nurses Organization of Veterans Affairs, National Association of VA Physicians and Dentists, National Organization of Veterans' Advocates, and the Advisory Committee, Veterans Consortium Pro Bono Program. In addition, testimony was submitted for the hearing record by the Honorable Preston M. Taylor, Jr., Assistant Secretary of Labor for Veterans' Employment and Training, and by the Non Commissioned Officers Association of the United States.

COMMITTEE MEETING

After carefully reviewing the testimony from the foregoing hearings, the Committee met in open session on July 24, 1996, and voted unanimously to report S. 1359 with an amendment in the nature of a substitute that includes provisions from S. 1359, as introduced and amended, S. 293, S. 403, S. 425, S. 548, S. 612, S. 644, S. 1750, S. 1752, and S. 1753, as well as original provisions extending expiring authorities relating to VA's authority to provide reimbursed medical care to Department of Defense beneficiaries and VA evaluations of the health status of Persian Gulf veterans, and requiring that VA transmit to the Congress a report concerning mentally ill veterans.

SUMMARY OF S. 1359 AS REPORTED

S. 1359 as reported (hereinafter referred to as the "Committee bill") consists of five titles summarized below that would affect various changes in the administration and personnel practices of VHA; would modify existing authorities relating to the Readjustment Counseling Service and make other modifications and extensions relating to the provision of health care by VA; would establish mental illness research, education, and clinical centers and reopen VA authority to establish research corporations; would establish a pilot program for the provision of hospice care services; and would establish standards for the provision of mammography services by VA.

TITLE I—VETERANS HEALTH ADMINISTRATION

Title I contains amendments to title 38, United States Code, that would:

1. Expand the authority of the Department of Veterans Affairs (VA) to enter into agreements with other health care providers to share VA health care resources with such providers, and to procure health care resources from such providers (section 101).
2. Modify the time period during which VA is barred from implementing certain administrative reorganizations (section 102).
3. Repeal limitations now in force with respect to contracts for the performance of VA employee-performed activities (section 103).
4. Amend terminology referring to VA "hospitals" so as to expand the sites where medical residents and interns can provide services

to VA under disbursement agreements with medical schools and community hospitals (section 111).

5. Repeal the bar to remunerated outside professional activities by VA health care professionals (section 112).

6. Authorize the temporary waiving of special pay refund obligations when VA physicians or dentists enter into residency training programs (section 113).

TITLE II—HEALTH CARE

Title II contains freestanding provisions and amendments to title 38, United States Code, that would:

1. Require the filing of a report before an organizational or administrative restructuring of the VA's Readjustment Counseling Service (RCS) could be undertaken (section 201(a)).

2. Require that VA annual budget submissions contain a separate "line item" delineating funds requested for RCS operations and administration (section 201(b)).

3. Require that VA provide readjustment counseling services to: (a) any veteran who served on active duty in a theater of combat operations during the Vietnam era; (b) any veteran who served on active duty during the Vietnam era if the veteran seeks, or has sought, such counseling before January 1, 2000; (c) any veteran who served on active duty in a theater of combat operations during any period of war; and (d) any veteran who served on active duty in an area other than a theater of combat operations if that area is determined by VA to have been an area in which hostilities occurred (section 202(a)).

4. Authorize VA to provide readjustment counseling services to other veterans, upon their request, to assist the veteran in readjusting to civilian life (section 202(a)).

5. Require that VA provide counseling services to the surviving parents, spouse, and children of any member of the Armed Forces who dies in a theater of combat operations or area of hostilities, or as a result of a disease, injury, or condition incurred while in service in a theater of combat operations (section 202(b)).

6. Authorize VA to provide counseling services to the surviving parents, spouse, and children of any member of the Armed Forces who dies while serving on active duty or from a condition incurred in or aggravated by such service (section 202(b)).

7. Establish an Advisory Committee on the Readjustment of Veterans to advise the VA on the readjustment needs of veterans, the nature and character of psychological problems arising from service, and the effectiveness of VA policies, organizational structures, and services, in providing for the readjustment needs of veterans (section 203).

8. Require VA to report on the feasibility and desirability of collocating Readjustment Counseling Service Vet Centers and VA outpatient clinics (section 204).

9. Require VA to report on the feasibility and desirability of providing limited health care services at VA readjustment counseling centers (section 205).

10. Authorize VA to make per diem payments to States which provide adult day health care services to veterans in State homes

if the veteran beneficiaries of such services are eligible for such services at VA (section 211(a)).

11. Authorize VA to furnish assistance to States in the construction or acquisition of facilities to provide adult day health care services (section 211(b)).

12. Extend until December 31, 1998, authority under which VA and the Department of Defense (DOD) enter into "sharing agreements" under which VA provides health care services, for reimbursement, to persons eligible for such services at DOD, or DOD-contractor, facilities (section 212).

13. Extend until December 31, 1998, the requirement that VA conduct a study to evaluate the health status of spouses and children of Persian Gulf War veterans (section 213).

14. Require VA to submit to the Congress any report submitted to the VA's Under Secretary of Health by VA's Special Committee for the Seriously Mentally Ill Veteran (section 214).

TITLE III—HEALTH CARE RESEARCH

Title III contains amendments to title 38, United States Code, that would:

1. Require the VA Secretary to designate not more than five VA health care facilities as locations for mental illness research, education, and clinical centers (MIRECCs), with at least one to be designated by January 1, 1997 (section 301(a)).

2. Provide that, to qualify for designation, a facility must demonstrate that it can: (1) maintain arrangements with an accredited medical school which provides training in psychiatry, and with a graduate program of psychology, under which residents and students receive training and education through regular rotation at the VA facility; (2) maintain an arrangement under which nursing, social work, or other allied health personnel receive training and education in mental health at the VA facility; (3) attract the participation of scientists who have demonstrated creativity and achievement in mental illness research and treatment; (4) maintain a policymaking advisory committee composed of VA mental health staff and research representatives from the affiliated schools; and (5) effectively conduct evaluations of the activities of the center (section 301(a)).

3. Provide that a peer review panel be used to determine the location of such centers so as to ensure that any such center meets the highest competitive standards of scientific and clinical merit prior to selection by the Secretary (section 301(a)).

4. Require the Secretary to ensure that the sites selected are located in various geographic areas (section 301(a)).

5. Require that at least three of the five centers emphasize the development of community-based alternatives to institutional treatment (section 301(a)).

6. Authorize the appropriation of $3.125 million for fiscal year 1997, and $6.25 million for each of fiscal years 1998, 1999, and 2000 for MIRECCs (section 301(a)).

7. Require VA to submit reports to Congress during 1997, 1998, and 1999 concerning the activities of MIRECCs (section 301(c)).

8. Reauthorize, through December 31, 2000, the establishment of nonprofit corporations at VA medical centers to provide for a flexi-

ble funding mechanism for the conduct of approved research at the medical center (section 302(a)).

9. Revise the contents of reports which VA is required to submit to the Congress annually with respect to such nonprofit corporations (section 302(c)).

TITLE IV—HOSPICE CARE SERVICES

Title IV contains freestanding provisions and amendments to title 38, United States Code, that would:

1. Require VA, during the period October 1, 1996–December 31, 2001, to conduct a pilot program to assess the feasibility and desirability of furnishing hospice care services to terminally ill veterans, and determine the most efficient and effective means of furnishing such services (section 402(a)).

2. Require VA to furnish hospice care services under the pilot program to any veteran who has a life expectancy of 6 months or less (as certified by a VA physician), and who is (a) entitled to VA hospital care, (b) eligible for and receiving VA hospital or nursing home care, (c) eligible for and receiving care in a community nursing home under a VA contract, or (d) eligible for and receiving care in a State veterans home for which VA is making per diem payments to offset the costs of that care (section 402(a)).

3. Specify that the hospice care services that VA must provide to veterans under the pilot program are: (a) the services to which Medicare beneficiaries are entitled; and (b) personal care services, including care or services relating to dressing, personal hygiene, feeding, and housekeeping (section 402(a)).

4. Require VA to establish hospice care demonstration projects that would provide these services at not fewer than 15, but not more than, 30 VA medical centers by one of three means: (a) a hospice operated by the VA medical center; (b) a non-VA hospice under contract with a VA medical center, which VA medical center furnishes necessary inpatient services; or (c) a non-VA hospice under contract with a VA medical center, which non-VA facility furnishes necessary inpatient services (section 402(a)).

5. Require that each of the three means for furnishing hospice care services be used at not fewer than five VA medical centers (section 402(a)).

6. Require that VA ensure, to the maximum extent feasible, that VA medical centers selected to conduct demonstration projects under the pilot program include facilities that: (a) are located in urban areas and rural areas; (b) encompass the full range of affiliations between VA medical centers and medical schools; (c) operate and maintain various numbers of beds; and (d) meet any additional criteria or standards that the Secretary may deem relevant or necessary (section 402(a)).

7. Provide that the amount paid by VA to a non-VA hospice under a hospice care services contract generally not exceed the amount that would be paid to that hospice under the Medicare hospice benefit, and authorize VA to pay an amount in excess of the Medicare reimbursement rate if VA determines, on a case by case basis, that the Medicare rate would not adequately compensate the hospice for the costs associated with furnishing necessary care to a terminally ill veteran (section 402(a)).

8. Require VA to designate not fewer than 10 VA medical centers that furnish less comprehensive hospice services than those which would be provided by the pilot program VA medical centers to serve as a "control group" (section 402(a)).

9. Require VA to ensure, to the maximum extent practicable, that terminally ill veterans receive information regarding their eligibility (if any) for Medicare's hospice care benefit (section 402(a)).

10. Require VA, not later than September 30, 1997, and on an annual basis thereafter until October 1, 2002, to submit periodic written reports to Congress on the pilot hospice care program (section 402(a)).

11. Require the Director of VA's Health Services Research and Development Service, not later than August 1, 2000, to submit to Congress a detailed report on the pilot program, including an assessment of the feasibility and desirability of furnishing hospice care services to terminally ill veterans, an assessment of the optimal means of furnishing such services, and recommendations, if any, for additional legislation regarding such care (section 402(a)).

12. Clarify that the pilot program would not preclude VA from furnishing hospice care services at VA medical centers not participating in the pilot program or the control group (section 402(c)).

13. Authorize the appropriation of funds to cover costs associated with the evaluation of the pilot program in the following amounts: (a) $1.2 million for FY 1997; (b) $2.5 million for FY 1998; (c) $2.2 million for FY 1999; and (d) $100,000 for FY 2000 (section 402(d)).

TITLE V—MAMMOGRAPHY STANDARDS

Title V contains freestanding provisions that would:

1. Require that all VA facilities that perform mammography be accredited by a private nonprofit organization designated by VA, and require that the designated organization be one that meets standards for accrediting bodies that are no less stringent than those established by the Department of Health and Human Services (HHS) pursuant to the Mammography Quality Standards Act of 1992 (section 502(a)).

2. Require VA, in consultation with HHS, to issue quality assurance and quality control standards for mammography services furnished in VA facilities that would be no less stringent than the HHS regulations to which other mammography providers are subject under the Mammography Quality Standards Act of 1992 (section 502(b)).

3. Require VA to issue such regulations not later than 120 days after HHS issues regulations to implement the Mammography Quality Standards Act of 1992 (section 502(b)).

4. Require VA to inspect mammography equipment operated by VA facilities on an annual basis in a manner consistent with requirements contained in the Mammography Quality Standards Act of 1992, except that VA would not have the authority to delegate inspection responsibilities to a State agency (section 502(c)).

5. Require VA health care facilities that provide mammography through contracts with non-VA facilities contract only with facilities that comply with HHS mammography quality assurance and quality control regulations (section 502(d)).

6. Require VA, not later than 180 days after it prescribes mammography quality assurance and quality control regulations, to submit a report to Congress on the implementation of those regulations (section 502(e)).

DISCUSSION

TITLE I—VETERANS HEALTH ADMINISTRATION

Title I of the Committee bill, which is derived from S. 1359 as introduced, and from S. 1750, S. 1752, and S. 1753, would modify certain administrative requirements and personnel policies under which VA now operates.

Subtitle A—Administration

Sec. 101. Revision of authority to share Medical facilities, equipment, and information

Under section 8153 of title 38, United States Code, VA is authorized to enter into sharing agreements, contracts, or other arrangements under which VA purchases or otherwise procures medical resources from community providers and shares VA medical resources with such providers. Such agreements allow both VA medical centers and community providers to provide medical care to their respective patient populations more efficiently by avoiding wasteful duplication of equipment and services within a local community.

VA sharing authority is significantly restricted in scope. For example, under section 8153, VA may only share "medical resources," and not, for example, risk assessment, accounting, or other nonmedical services it might need or be able to share with other providers. In addition, the "medical resources" that VA may procure or share must be "specialized" medical resources, a limitation which gives rise to questions concerning what resources are themselves sufficiently "specialized" to fall within section 8153's scope and whether certain resources within a particular community or setting might be "specialized" in that setting and not in others. Finally, VA may only enter into sharing agreements with "healthcare facilities (including organ banks, blood banks, or similar institutions), research centers, or medical schools." Other potential sharing partners—for example, health maintenance organizations, insurance carriers, individual physicians, or other individual care providers—are not included within section 8153's definition, thereby precluding VA medical centers from entering into sharing agreements with such organizations or individuals.

Section 101 of the Committee bill would ease these various restrictions by authorizing VA to enter into agreements with *any* non-VA health care provider for the mutual use or exchange of use of *any* health care resources. The Committee's intention is to strengthen VA's capabilities, especially in VA medical facilities in smaller cities and rural areas, to provide care to veterans.

Sec. 102. Waiting period for administrative reorganizations

VA has broad authority to organize its personnel and operations as it deems advisable for the efficient and timely delivery of serv-

ices to veterans. However, that authority is not unlimited. Before VA may proceed to implement an "administrative reorganization" as defined in section 510 of title 38, United States Code, it must first give notice to Congress and then wait until 90 days of continuous session have passed. (Continuity of session is broken by adjournment *sine die*. In computing the number of days of session, any day in which either House of Congress is not in session for an adjournment of more than 3 days is not counted.) An "administrative reorganization" which is subject to this "notice and wait" requirement is one in which there would be, in a particular fiscal year, full-time staff reductions at a covered field office or facility of 15 percent or more, or by a percent which, when added to the percent reductions (if any) made in the preceding fiscal year, is 25 percent or more.

The Committee has concluded that a 90-day waiting period, as defined by section 510(b), is longer than necessary to ensure that Congress receives adequate notice of, and has time to respond to, reorganizations that would significantly alter employment patterns in VA field facilities. Section 102 of the Committee bill would, therefore, reduce the waiting period to 45 days, 30 days of which are days within which Congress shall have been in continuous session as defined in current law.

Sec. 103. Repeal of limitations on contracts for conversion of performance of activities of Department health-care facilities

As discussed above, VA currently has authority to enter into "sharing agreements" which allow it to procure "medical resources" from other health care providers in the community. That authority, which currently allows a VA medical center to purchase a wide range of services, for example, anesthesiology services, from community providers, and this authority would be expanded under section 101 of the Committee bill. Nonetheless, section 8110(c) of title 38, United States Code, bars VA medical centers from converting any VA "direct patient care activity" or any "activity incident to direct patient care" to an activity carried out by a non-VA entity; and it allows other activities at a VA medical center to be "contracted out," but only in accordance with procedures and limitations specified in section 8110(c).

Section 1103 of Public Law 103–446 suspended the operation of section 8110(c) for fiscal years 1995 through 1999. This action was taken in conjunction with the enactment of a limitation on the effect of government-wide personnel reductions on VA's staff. In so doing, Congress recognized that VA medical centers needed the ability to convert some functions as part of the overall reductions in government staffing. As is recognized by the policy underlying the amendments to VA's sharing authority, VA facilities must have the ability to procure services from other community sources when such sources can provide them more efficiently than VA can on an "in-house" basis. By such arrangements, efficiencies of scale can be achieved by the seller, thereby yielding lower costs to the buyer and the stretching of limited VA resources.

These considerations have not changed since enactment of the suspension of section 8110(c) by Public Law 103–446. Nor are they

likely to change for the foreseeable future. Section 103 of the Committee bill, therefore, would repeal section 8110(c).

Subtitle B—Personnel

Sec. 111. Revision of administrative authorities regarding residencies and internships

Physicians in training (residents and interns) at medical schools with which VA medical centers are affiliated typically receive part of their training at VA medical centers and part of their training at the medical school or other community facilities or both. To ease the logistics of VA paying its share of the stipend owed to such residents and interns, section 7406 of title 38, United States Code, authorizes VA to enter into "disbursement agreements" with medical schools and community hospitals. Those agreements provide that one of the non-VA facilities will pay the physician in training, and VA will reimburse VA's share to the paying hospital.

As section 7406 currently reads, VA is authorized to enter into such agreements to provide for the payment of residents and interns who treat patients "in a Department [of Veterans Affairs] hospital." Physician training, however, does not take place in VA hospitals only. Residents and interns also train in VA outpatient clinics, nursing homes, domiciliaries, and other VA health care facilities.

Section 111 would amend section 7406 to authorize payments to residents and interns who provide services "in any [VA] facility furnishing hospital care or medical services", rather than in VA hospitals alone. The Committee intends that these common sense arrangements be available to simplify VA personnel management irrespective of the character of the medical facility in which a resident or intern is receiving VA training.

Sec. 112. Remunerated outside professional activities by Veterans Health Administration personnel

Section 7423(b)(1) of title 38, United States Code, bars full-time VA health care personnel who are employed under the title 38 personnel system—physicians, dentists, podiatrists, optometrists, registered nurses, physician assistants, and expanded-function dental auxiliaries—from "assum[ing] responsibility for the medical care of any patient other than a [VA] patient. * * *" Thus, these full-time VA health care professionals may not "moonlight," except where necessary to meet unmet community health care needs on a short-term basis. Part-time VA employees are free to practice their professions elsewhere.

In urging that the Congress eliminate the "moonlighting" ban with respect to three professions—registered nurses, physician assistants, and expanded-function dental auxiliaries—VA testified as follows at the Committee's May 23, 1996, hearing:

> VA requested this legislation because the current restrictions on moonlighting for these employees is [sic] outdated. Removal of these restrictions on an employee's use of personal time will allow VA to become more competitive with employers who impose no such restriction. The original purpose of the outside-professional-activities restriction

was to ensure the availability of health care professionals who are responsible for around-the-clock care of VA patients. VA has considerable flexibility to ensure coverage of these three professions and no longer uses this authority to provide coverage.

In addition, VA posited two additional reasons for eliminating the moonlighting ban with respect to registered nurses, physician assistants, and expanded-function dental auxiliaries: negative effect on employee morale, and skill-enhancement advantages to be gained from outside professional employment opportunities. The Committee concludes that these considerations apply equally with respect to all of the professions which are now subjected to the moonlighting ban. The Committee bill, therefore, would repeal the ban.

Sec. 113. Authority to waive special pay agreement refund requirements for physicians and dentists who enter into residency training programs

Under current law, VA is authorized to pay "special pay" to full- and part-time VA physicians (ranging from $4,000 to $45,000 per year depending on level of experience, qualifications, and duties) in order to attract them to VA employment. Physicians and dentists are required, however, to refund "special pay" to VA (on a sliding scale) in the event that they leave VA employment before 4 years expire. VA may waive the refund provision, but only if the physician or dentist leaves VA employment "as a result of circumstances beyond the control of the physician or dentist."

VA physicians and dentists are often presented with opportunities to enhance their skills by participating in residency training programs which require that they leave VA employment. It is consistent with VA's interests that its employees be allowed, and encouraged, to gain advanced training—so long as the physician or dentist returns to VA employment at the completion of such training. The Committee bill, therefore, would allow VA to suspend the refund provision during training. Upon departure from training, the refund provision would be reinstated, and if the physician or dentist did not return to VA employment it would again be operative.

TITLE II—HEALTH CARE

Title II of the Committee bill, which is derived from S. 293 and S. 403, and which also contains original provisions, would modify VA Readjustment Counseling Service programs, authorize VA to make per diem payments to States which provide adult day health care services to veterans, and extend and modify other provisions of law.

Subtitle A—Readjustment Counseling

Background

Within the Department of Veterans Affairs, the Readjustment Counseling Service (RCS) of the Veterans Health Administration (VHA) provides readjustment counseling and mental health serv-

ices, as currently specified in section 1712A of title 38, United States Code, to two eligible veteran populations: all veterans who served on active duty during the Vietnam era; and all veterans who served on active duty after May 7, 1975 (the end of the Vietnam era), in an area at a time during which hostilities occurred in such area. In the case of Vietnam- era veterans, as distinguished from post-Vietnam-era veterans, there is no requirement of service in Vietnam (or in any other area of hostilities) for eligibility for readjustment counseling services. There is no provision in section 1712A for the provision of such services, on a "mandatory" or space-available basis, to other veterans.

Readjustment counseling services are furnished through 201 Vet Centers located throughout the United States and in Puerto Rico and the Virgin Islands, and through contracts with non-VA entities. The RCS program is managed by a director, located in the central office of VHA, through a regional management structure.

VA is also authorized to provide consultation, professional counseling, training, and mental health services to members of a veteran's immediate family (and to the veteran's legal guardian or household caregiver) if such services are necessary in connection with the treatment of the veteran's service-connected disability or, at VA's discretion and under certain circumstances, the veteran's non-service- connected disability. Persons who were actually receiving such services at the time of the veteran's unexpected death, or the veteran's death while participating in a VA-conducted hospice (or similar) program, may also receive limited-term bereavement counseling services from VA.

Committee bill

Sec. 201. Organization of the readjustment counseling service in the Department of Veterans Affairs

The Committee bill specifies that VA may not alter the organizational or administrative structure of VA's RCS without first submitting a report to the Senate and House Committees on Veterans' Affairs detailing the proposed alteration or revision and waiting for the lapsing of a 60-day period (excluding days on which either House of Congress is not in session due to an adjournment of more than 3 calendar days). It also requires a separate accounting of VA's proposed RCS budget in each annual budget request submitted by VA to the Congress.

Sec. 202. Expansion of eligibility for readjustment counseling and certain related services

The Committee bill would modify the universe of veterans to whom VA would provide readjustment counseling (and related) services on mandatory and "as requested" bases. Mandatory services would continue to be provided to all Vietnam-era veterans (irrespective of actual service in Vietnam) if the veteran seeks, or has received, such services before January 1, 2000. At that time, such services would be limited to Vietnam-era veterans who served on active duty in a theater of combat operations (unless services had previously been sought). With respect to non-Vietnam-era veterans—those who served before or after that era—VA would be re-

quired to provide such services, at the veteran's request, to those who served in a theater of combat operations during a period of war or in any other area during a period in which hostilities occurred in such area. Other veterans could be provided such services by VA, but after January 1, 2000 (unless the veteran was already receiving such services), VA would be required to provide readjustment counseling services only to veterans who served in a combat theater during a period of war, or who served in an area where hostilities occurred.

The Committee bill would require VA to provide bereavement counseling services to the surviving parents, spouse, and children of a deceased service member who had died in a combat theater during a period of war (or who died as a result of a disease, injury, or condition incurred while in such service), or who had died in an area in which hostilities were occurring while in service there during such hostilities. The parent, spouse, and children of other deceased veterans who have died while serving, or who have died from a condition incurred or aggravated in service, could be provided such services by VA, but VA would not be required to provide such services.

Sec. 203. Advisory Committee on the readjustment of veterans

The Committee bill would create an 18-member Advisory Committee on the Readjustment of Veterans to advise VA on, among other things, the readjustment needs of veterans and the effectiveness of VA programs and structures in providing for the readjustment needs of veterans. The original members of this committee will be the members on the date of enactment of this legislation of the administratively established Advisory Committee on the Readjustment of Vietnam and Other War Veterans. The Advisory Committee would be required to report annually to the Secretary of Veterans Affairs.

Sec. 204. Report on collocation of vet centers and Department of Veterans Affairs outpatient clinics

The Committee is aware of proposals to collocate RCS Vet Centers and VA outpatient clinics. So that the Committee can properly assess such proposals, the Committee bill requires that VA submit a report to the Congress, within 6 months of enactment of the Committee bill, thoroughly analyzing the feasibility and desirability of the collocation concept.

Sec. 205. Report on provision of limited health care services at readjustment counseling centers

The Committee is also aware of proposals to provide limited health care services at Vet Centers. So that the Committee can properly assess such proposals, the Committee bill also requires that VA submit a report to the Congress, within 6 months of enactment of the Committee bill, on the feasibility and desirability of providing a limited battery of health care services (including ambulatory services and health care screening services) at Vet Centers.

Subtitle B—Other Provisions

Sec. 211. Payment to States of per diem for veterans receiving adult day health care

VA currently supports State efforts to provide services to veterans by (1) making grants to States to assist them in building and initially supplying State-owned veterans domiciliaries or nursing home facilities ("State homes") and (2) by making per diem payments to States (not to exceed one half of the cost of the State-provided care) at specified rates for each veteran receiving domiciliary, nursing home, or hospital care in a State home who is eligible for the same services at a VA facility.

Section 211 of the Committee bill would add an additional form of assistance to the States: support of State home-provided adult day health care services. VA would provide such assistance via the two mechanisms which currently assist State homes. VA would be authorized to make grants to assist the States in expanding, remodeling, or altering existing State home facilities (but not building new facilities) for the provision of such services, and it would be authorized to make per diem payments (in a rate deemed appropriate by VA) to States providing such services to veterans who are eligible for adult day health care at VA.

Sec. 212. Expanded health care sharing agreement authority

VA and the Department of Defense (DOD) are required to promote the sharing of health care resources between the two Departments by establishing guidelines for entering into agreements for the mutual use or exchange of use medical facilities and other resources. In 1992, that authority was expanded by Public Law 102–585 so as to authorize the head of a VA health care facility to: (a) enter into sharing agreements with (1) the head of a DOD facility, (2) any other DOD official responsible for the furnishing of health care services to Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) beneficiaries, or (3) a contractor responsible for the furnishing of health care services to CHAMPUS beneficiaries; and (b) to enter into sharing agreements that would provide for the furnishing of care to Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and CHAMPUS beneficiaries. Those agreements may provide for the waiver, in whole or in part, of copayments and deductibles for care provided under such agreements. That expanded authority will expire on October 1, 1996.

The Committee has concluded that the temporary expansion of sharing authority enacted in 1992 has operated to the mutual advantage of VA and DOD, and to the advantage of VA and DOD beneficiaries. The Committee bill, therefore, contains an original provision that would extend that authority through December 31, 1998.

Sec. 213. Evaluation of health status of spouses and children of Persian Gulf war veterans

Section 107 of Public Law 103–446 directs VA to conduct a study to evaluate the health status of spouses and children of Persian Gulf War veterans who display symptoms that might be associated

with a veteran's service in the Gulf to determine the nature and extent of the association, if any, between those illnesses and those of the veteran. This study is to be carried out between November 1, 1994, and September 30, 1996.

The mandated study has not yet been concluded, and it remains unclear at this time whether there is an association between Persian Gulf service and maladies suffered by veterans' spouses and children. The Committee bill, therefore, would extend the period within which this study would be conducted until December 31, 1998.

Sec. 214. Transmittal of reports of Special Committee for the seriously mentally ill veteran

The Committee bill contains an original provision directing that VA submit all such reports to the Committees on Veterans' Affairs of the Senate and the House together with the comments of the Under Secretary for Health on those reports.

TITLE III—HEALTH CARE RESEARCH

Title III of the Committee bill, relating to health care research, includes two provisions: Section 301, which is derived from S. 425 (which was, in turn, derived from S. 1512 of the 103rd Congress which the Committee reported on March 17, 1994, and the Senate passed on March 24, 1994), would establish Mental Illness Research, Education, and Clinical Centers; and section 302, which is derived from S. 644, would facilitate VA research by reauthorizing the establishment of research corporations at VA medical centers.

Sec. 301. Mental illness research, education, and clinical centers

Background

The October 20, 1985, Report of the Special Purpose Committee to Evaluate the Mental Health and Behavioral Sciences Research Program of the VA, which was chaired by Dr. Seymour Kety ("Kety Committee"), concluded that research on mental illness and training for mental health specialists at VA facilities were inadequate. The report noted that approximately 40 percent of all VA beds were occupied by veterans who suffer from mental disorders, whereas less than 10 percent of VA's research resources were directed toward mental illness. These percentages have remained at similar levels in subsequent years.

In order to improve and expand the capability of VA health care facilities to respond to the needs of veterans with mental illnesses, the Kety Committee recommended that VA centers of excellence be established to develop first-rate psychiatric research programs within VA. Such centers would provide state-of-the-art treatment, increase innovative basic and clinical research opportunities, and enhance and encourage continuing education and training in the treatment of mental illness.

Based on the recommendations of the Kety Committee, the Senate Committee on Veterans' Affairs began efforts 8 years ago to encourage more research into mental illnesses and to establish centers of excellence. First, legislation enacted on May 20, 1988, Public Law 100–322, included a provision to add a specific reference to

mental illness research in the statutory description of VA's medical research mission, now set forth in section 7303(a)(2) of title 38, United States Code. This reference in the law is intended to express the importance of research to mental health care and thereby to help counteract historical patterns of relatively underfunded mental illness research.

Second, the Committee report accompanying that legislation (S. Rept. 100–215, p. 138) urged VA to establish three centers of excellence, or Mental Illness Research, Education, and Clinical Centers ("MIRECCs"), as proposed by the Kety Committee. The VA has yet to take action to do so.

The Committee notes that the January 1991 final report of the VA Advisory Committee for Health Research Policy recommended that VA establish MIRECCs as a means of increasing opportunities in psychiatric research and encouraging the formulation of new research initiatives in mental health care, as well as maintaining the intellectual environment so important to quality health care. The report stated that "[these] centers could provide a way to deal with the emerging priorities in the VA and the Nation at large."

Committee bill

The Committee bill would require VA to establish MIRECCs at not more than five VA facilities which are geographically dispersed and which meet certain specified criteria. The purpose of the MIRECCs would be: (1) to facilitate the improvement of health care services for eligible veterans suffering from mental illness, especially from conditions which are service connected, through research, the education and training of health personnel, and the development of improved models of clinical services; and (2) to develop improved models for the furnishing of clinical services.

The proposed MIRECCs would be modeled after the successful Geriatric Research, Education, and Clinical Centers (GRECCs) which were authorized in 1980 in section 302 of Public Law 96–330. The MIRECCs would be designed to: (1) attract clinicians and investigators with a clear and focused clinical research mission, such as PTSD, schizophrenia, or drug and alcohol abuse; (2) provide training and educational opportunities for students and residents in psychiatry, psychology, nursing, social work, and other professions which treat individuals with mental illness; and (3) develop new models of effective care and treatment for veterans with mental illnesses, especially those which are service connected.

The Committee believes that the establishment of MIRECCs would also encourage research into outcomes of various types of treatment for mental illnesses, an aspect of mental illness research which, to date, has not been fully pursued either by VA or other researchers in the field.

In order to designate a facility as the site for a MIRECC, the Secretary, upon the recommendation of the Under Secretary for Health, would have to determine that the facility has developed (or might reasonably be expected to develop): (1) arrangements with an affiliated medical school and an affiliated graduate program of psychology for the regular rotation of their residents and students through the center; (2) an arrangement under which nursing or other allied health personnel receive education and training in

mental health care through regular rotation through the facility; (3) the ability to attract superior mental illness researchers; (4) a policymaking advisory committee composed of health care and research representatives of the VA facility and the schools involved; and (5) the capability to evaluate effectively the activities of a MIRECC.

The Committee bill would require that a peer review panel be used to determine the location of such centers so as to ensure that, in addition to being geographically diverse, any such center meets the highest competitive standards of scientific and clinical merit prior to selection by the Secretary. Also, at least three of the five centers would be required to emphasize the development of community-based alternatives to institutional treatment.

The Committee bill would promote research at the MIRECCs by requiring that, in the awarding of research funds for mental illness projects, MIRECC applications be given a priority. Centers would include an emphasis on the psychosocial dimension of mental illness and on developing models for furnishing care and treatment of mental illness. Further, the Committee bill would promote the dissemination of information regarding all aspects of MIRECC activities throughout the Veterans Health Administration (VHA) by requiring the Under Secretary for Health to develop continuing education programs.

Finally, beginning February 1, 1997, the Secretary would be required to submit three annual reports to the House and Senate Committees on Veterans' Affairs on the research, educational, and clinical care activities at each MIRECC and on efforts to disseminate the information throughout the VA health care system. The administration of the program would be assigned to the VA Central Office official responsible for mental health and behavioral sciences, which is currently the Director of Mental Health and Behavioral Sciences.

The Committee also urges VA—as it has in the past—to create a Mental Illness Research Service, similar to research services that exist for each of the other categories of research expressly mentioned in the statutory provision, section 7303(a)(2), which establishes VA's research mission. Section 135 of Public Law 100–322, which originated in this Committee, added specific mention of mental illness to the description of VA's research mission in this section in order to emphasize the importance of such research and the establishment of such a service. The Committee remains convinced that the creation of a separate service with its own budgetary allocation would help VA to pursue more creatively cost-effective and innovative treatment for veterans suffering from mental illness.

Sec. 302. Research corporations

During the period May 20, 1988, through December 31, 1992, VA was authorized to establish nonprofit corporations at its medical centers to provide for flexible funding mechanisms for the conduct of approved research at the medical centers. Such corporations were authorized to receive and administer funds other than appropriated funds—for example, gifts or research grants—received to support VA research efforts at the medical center.

Authority to establish such research corporations expired on December 31, 1992. The Committee has learned that some VA medical centers did not establish research corporations when the opportunity was presented. The Committee would reopen the authority to do so, effective through December 31, 2000. The Committee bill would also revise the reporting requirements currently imposed on such corporations so as to expand the amount of information the Congress receives on both contributions to, and expenditures by, these research corporations. Such additional information will facilitate greater oversight of these entities by the Committee.

TITLE IV—HOSPICE CARE SERVICES

Title IV of the Committee bill, which is derived from S. 612 (which was, in turn, derived from section 203 of S. 1030 of the 103rd Congress which the Committee reported on September 8, 1993, and the Senate passed on May 25, 1994), would establish a hospice care pilot program in VA.

Sec. 402. Programs for furnishing hospice care to veterans

Background

As the Committee noted in its report (S. Rept. 103–136) accompanying S. 1030 in the 103rd Congress, it is important that VA develop cost-effective methods of providing treatment to veterans, particularly older veterans, who are most likely to seek VA services in the coming years. Among the services that can best meet the needs of older veterans are community-based, noninstitutional services, including hospice care, which provides a compassionate alternative to customary curative care for terminally ill persons.

While the record before the Committee on hospice care, including hearings in 1991, 1993, and 1995, indicates that VA has focused on hospice care, the Committee remains concerned that VA has moved too cautiously in establishing programs which achieve the goals of hospice care. On April 30, 1992, VA issued a directive that required all VA medical centers to implement hospice programs. However, that directive provided only vague guidelines regarding the manner in which VA medical centers should provide hospice care. As a result, significant variations now exist in the manner in which hospice care is provided.

It is reported that, at present, all VA medical centers have hospice consultation teams (consisting of at least a physician, a nurse, a social worker, and a chaplain). In addition, 56 of 171 VA medical centers have inpatient hospice units, freestanding buildings, or separate units where a home-like atmosphere is created. While this is an increase in the total number of inpatient units since 1993, it is not clear that it demonstrates a significant change in the overall effort in support of hospice care. VA has submitted material to the Committee stating that "most VA inpatient hospice units are small with an average size of 7 beds." Other VA medical centers provide pain management and other services to terminally ill veterans in units in which hospice rooms are adjacent to rooms in which other patients are administered curative care. Still other VA medical centers provide some hospice services such as caregiver counseling and pain management.

Unfortunately, many VAMCs' hospice efforts offer only an assessment of a terminally ill veteran's needs and a referral to a non-VA hospice. While such referrals may benefit some veterans, they are of little value to those veterans who are not entitled to Medicare or Medicaid or who lack health insurance coverage for hospice care. Because VA has no authority under current law to contract with non-VA hospices, veterans of limited means can be left with the difficult option of foregoing hospice care due to inability to pay for such care.

The Committee is convinced that VA should provide hospice care. It is uncertain, however, as to the best way for the Department to provide such care. Some assert that the only bona fide form of hospice care is a program offering both home and inpatient palliative care (noncurative care focusing on alleviating pain and other symptoms) and support services to meet the psychological, social, and spiritual needs of patients and their families. Others believe that equally effective care can be furnished by integrating hospice concepts into customary care. Similarly, there is considerable disagreement as to whether veterans who wish to receive hospice care are best served by VA hospice programs or through contracts with non-VA providers.

To this point, VA has not undertaken sufficient research to answer with any degree of certainty the most appropriate way in which it might furnish hospice care. Therefore, the Committee believes that a study of the ways in which hospice care can successfully be furnished to veterans is warranted.

Given the growing numbers of elderly or terminal VA patients who could benefit from hospice care, demand for VA hospice care is likely to increase. Research related to the provision of such care is critical.

Committee bill

The Committee bill would require VA to conduct a 5-year pilot program to evaluate the best way to provide hospice care. The Committee's main goals are to make hospice care services more readily available to greater numbers of veterans and to develop information about how VA might best offer these services.

The Committee bill would require VA to set up demonstration projects at 15 to 30 VA sites to provide hospice care by one of three means: (1) a hospice operated by a VA medical center; (2) a non-VA hospice under contract under an arrangement providing for the furnishing of needed inpatient care at VA facilities; or (3) a non-VA hospice under contract under an arrangement providing for the furnishing of needed inpatient care at non-VA facilities.

The Committee bill generally would require VA to follow Medicare's policy in setting reimbursement rates. Contract hospice rates would generally be capped at the Medicare rates. However, exceptions could be made in cases in which the Secretary determines that the Medicare rate would not compensate a non-VA hospice for providing a veteran with necessary care. In such cases, the Secretary could either pay a rate higher than the Medicare rate or provide in-kind services to the contract organization. The Committee bill includes this provision to ensure that veterans for whom care

is extraordinarily expensive due to the nature of their condition, such as veterans with AIDS, would not excluded from the program.

Under the Committee bill, the VA pilot program would have to include at least 10 VA medical centers that offer a less comprehensive range of services to terminally ill veterans as part of the evaluation. In including a comparison group in the evaluation, the Committee seeks to determine whether furnishing a less comprehensive range of services is useful at medical centers in which the numbers of veterans desiring such services may not be sufficient to justify a full-scale hospice program.

The Committee bill would require that the Director of VA's Health Services Research and Development Service (HSR&D) conduct an evaluation of the various models for furnishing hospice care. Lest there be a diversion of scarce funds from other meritorious health services research projects, the Committee bill would authorize the appropriation of additional funds to HSR&D to cover costs associated with the mandated evaluation.

Finally, to ensure that VA patient care is not compromised or diminished in any way by the pilot program, the Committee bill would provide that VA is not precluded from furnishing hospice care services at VA medical centers not participating in the pilot program or the control group. Indeed, the Committee encourages that VA not only maintain such services, but that it expand them.

TITLE V—MAMMOGRAPHY STANDARDS

Title V of the Committee bill, which is derived from S. 548 (which in turn was derived from section 106 of S. 1030 of the 103rd Congress which the Committee reported on September 8, 1993, and the Senate passed on May 25, 1994) would require VA to establish standards for the provision of mammography services by VA.

Sec. 502. Mammography quality standards

Background

The Mammography Quality Standards Act of 1992, Public Law 102–539, requires that health care facilities which are subject to that law be certified by the Department of Health and Human Services (HHS) as meeting specified standards for equipment, personnel, and quality assurance. That law, however, does not apply to VA facilities.

The Committee believes that women veterans who receive care from VA facilities should have services that are equal or superior to those provided elsewhere. VA agrees. In a letter dated July 12, 1993, to the then-Chairman of the Committee, Senator Rockefeller, VA Secretary Jesse Brown wrote, "It is my intent that VA will comply with standards equal to those set forth in the Mammography Quality Standards Act of 1992 for all mammography done within VA facilities and require that all contracts and sharing agreements for mammography include a provision for compliance." At the Committee's October 25, 1995, hearing, Dr. Kenneth Kizer, VA's Under Secretary for Health, reiterated Secretary Brown's commitment, stating as follows:

> I am sure you all will be pleased to know that VA policy now requires compliance with the requirements of the

1992 Mammography Quality Standards Act. Moreover, all VA facilities furnishing mammography services are currently using the FDA's guidelines.

Committee bill

The Committee bill would ensure that the goal of giving women veterans safe and accurate mammograms continues to be met by requiring that the Secretary promulgate quality assurance and quality control standards for VA facilities that furnish mammography services. Those standards would be no less stringent than the HHS standards for other mammography providers as promulgated under the Mammography Quality Standards Act of 1992. VA facilities that contract with non-VA facilities would be required to contract only with facilities that comply with that act.

VA would be required to issue these standards no later than 120 days after the Secretary of HHS issues regulations to implement that act. In addition, VA would be required, not later than 180 days after prescribing its own mammography standards, to submit a report to the House and Senate Committees on Veterans' Affairs on the implementation of those regulations.

The Committee bill would also require that VA facilities that furnish mammography services be accredited by a private nonprofit organization designated by VA. VA would be permitted to designate only an accrediting body that meets the standards for accrediting bodies issued by HHS for purposes of accrediting mammography facilities subject to Public Law 102–539. The American College of Radiology (ACR) currently administers a voluntary accreditation program for mammography providers and, at the present time, is the only accrediting body that meets those requirements. Thus, the Committee anticipates that, under current circumstances, ACR would serve as VA's accrediting body under the Committee bill.

Finally, the Committee bill would require VA to ensure that mammography equipment operated by VA facilities is inspected on an annual basis in a manner consistent with requirements contained in the Mammography Quality Standards Act of 1992 concerning annual inspections of mammography equipment by HHS, except that VA would not have the authority to delegate inspection responsibilities to a State agency. The Committee expects VA to correct any deficiencies uncovered as a result of these inspections.

COST ESTIMATE

In compliance with paragraph 11(a) of Rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office (CBO), estimates that the costs resulting from the enactment of the Committee bill (as compared to costs under current law), as scored against the current CBO baseline during the remainder of FY 1996 and for the first 5 years following enactment, would have no effect on direct spending during fiscal years 1996 through 1998, and would have no effect on Federal direct spending during each year in fiscal years 1999 through 2002. The bill would not affect the budgets of State and local governments. The cost estimate provided by CBO, setting forth a detailed breakdown of costs follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 2, 1996.

Hon. ALAN K. SIMPSON,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 1359, the Veterans' Medical Programs Amendments of 1996, as ordered reported by the Senate Committee on Veterans' Affairs on July 24, 1996.

The bill would affect direct spending and thus would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JUNE E. O'NEILL, *Director.*

Attachment.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 1359.

2. Bill title: The Veterans' Medical Programs Amendments of 1996.

3. Bill status: As ordered reported by the Senate Committee on Veterans' Affairs on July 24, 1996.

4. Bill purpose: The bill would address programs for veterans medical care including mental illness centers, a pilot program for hospice care, payments to state homes providing adult day health care, health assessments of spouses and children of veterans of the Persian Gulf War, and readjustment counseling services.

5. Estimated cost to the Federal Government: The following table summarizes the budgetary impact of S. 1359, which would depend on subsequent appropriations action.

[By fiscal year, in millions of dollars]

	1996	1997	1998	1999	2000	2001	2002
SPENDING SUBJECT TO APPROPRIATIONS ACTION							
Spending Under Current Law:	16,559	17,171	17,773	18,397	19,040	19,701	20,384
Estimated authorization level[1]	16,880	17,762	17,746	18,328	18,969	19,629	20,310
Estimated outlays.							
Proposed Changes:							
Estimated authorization level	0	18	23	22	20	15	15
Estimated outlays	0	17	22	23	21	15	15
Spending Under S. 1359:							
Estimated authorization level	16,559	17,189	17,796	18,419	19,060	19,716	20,399
Estimated outlays	16,880	17,779	17,768	18,351	18,990	19,644	20,325

[1] The 1996 figure is the amount already appropriated. The amounts shown for 1997–2002 adjust the 1996 appropriation for projected inflation. If appropriations are held to the 1996 level, then beginning in 1997 the authorization level and outlays would both equal about $16,559 million each year.

6. Basis of estimate: The estimate assumes enactment of the bill by October l, 1996, and appropriation of the authorized amounts for each fiscal year. CBO used historical spending rates for estimating outlays.

Direct spending

Section 101 would grant VA broad authority to share resources with other entities and individuals. These sharing agreements would allow VA to collect and spend receipts derived from these agreements. This spending would not be subject to appropriations action. This section would have no net budgetary impact in the long run.

Authorization of appropriations

This bill contains several provisions that would be subject to appropriations action. These provisions would expand eligibility for readjustment counseling services to all combat veterans, authorize per diem payments to state veterans' homes for providing adult day health care, continue a program to monitor the health of Persian Gulf veterans' families, authorize operation of mental health centers in VA facilities, and create a pilot program to provide hospice care for terminally ill veterans.

Expansion of eligibility for readjustment counseling services

Section 202 would expand eligibility for readjustment counseling to any veteran who served in a theater of combat operations while on active duty. Counseling would also be provided to a parent, spouse, or child of a veteran who dies while on active duty. Current law provides for counseling to veterans who served during the Vietnam era or in a theater of combat operations after May 1975. This section would cost about $11 million a year.

The bill would apply primarily to the 3 million veterans who served in a combat theater during the Korean conflict or World War II. CBO estimates that the World War II and Korean War veterans covered by the bill would generate about 132,000 visits a year based on the estimated number of visits to counseling centers from comparable Vietnam veterans and the assumption that elapsed time would make the new beneficiaries only one-fourth as likely to seek counseling. Based on a current average cost of about $82 per visit, the cost of providing expanded counseling services under the bill would be about $10 million a year.

The cost of bereavement counseling for relatives of those who die while on active duty would be about $1 million a year. Based on data from the Department of Defense (DoD), the number of active-duty deaths is expected to be about 1,400 per year during the estimating period. CBO estimates that on average, one family member per casualty would seek this counseling.

Per diems for adult home day care

Section 211 would authorize VA to pay per diems to state veterans' homes for providing adult day health care (ADHC). Based on a recent survey of state homes conducted by the National Association of State and Veterans Homes, CBO estimates that several state homes would be interested in offering ADHC under the bill. Because no state homes now offer ADHC and legislation at the state level may still be necessary, per diem payments would not have a significant cost until 1999. As more states offer ADHC, per diem payments would increase to $2 million by 2002.

The estimate assumes that the number of veterans participating in the program would increase from 60 in 1998 to about 300 by 2002. Although the bill would not authorize a specific per diem rate, this estimate assumes that the rate would be the same as the rate VA pays state homes that provide nursing home care—about $17 per veteran per day.

This section would also authorize VA to make grants to states to finance the renovation or expansion of state veterans' homes in order to provide ADHC. The estimate assumes that one major or two to three minor projects every year would result in an annual cost of about $2 million.

Health status of spouses and children of Persian Gulf veterans

In 1994, VA established a program to evaluate any illnesses that may have resulted from having a spouse or parent who served in the Persian Gulf War. Section 213 would extend the program for two years and would continue to limit total expenditures to no more than $2 million. To date, VA has spent around $360,000 on the program.

Mental illness research, education and clinical centers

Section 301 would authorize research, education, and clinical centers to assist veterans suffering from mental illnesses, especially illnesses related to military service. The bill would authorize appropriations of $3 million in 1997 and $6 million a year for 1998–2000 in addition to authorizing VA to use funds appropriated for VA's medical care and prosthetic research accounts for the mental health centers.

Hospice Care Pilot Program

The bill would create a pilot program to provide hospice care for terminally ill veterans. Section 492 would authorize appropriations of $1.2 million in 1997, $2.5 million in 1998, $2.2 million in 1999 and $100,000 in 2000.

Sharing agreements

Section 101 would allow VA to agree to share equipment and other resources with a broad range of individuals and entities. These agreements would allow the resources to be used more efficiently and lead to budgetary savings or costs depending on the extent that VA would otherwise purchase or forgo the resource. CBO cannot estimate the budgetary impact of this provision.

Section 212 would extend through December 31, 1998, an expansion of sharing agreements between VA and the Department of Defense (DoD) that enable the two agencies to treat patients eligible for each other's programs. Because current agreements cover a relatively small number of beneficiaries, this provision would probably involve relatively low costs.

7. Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1998. The bill would have the following pay-as-you-go impact:

[By fiscal years, in millions of dollars]

	1996	1997	1998
Change in outlays	0	0	0
Change in receipts		(1)	(1)

[1] Not Applicable.

8. Estimated cost to State, local, and tribal governments: S. 1359 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act of 1995 (Public Law 104–4). The bill would provide federal assistance to states that opt to construct and operate adult day health facilities for veterans.

9. Estimated impact on the private sector: This bill would impose no new federal private-sector mandates as defined in Public Law 104–4.

10. Previous CBO estimate: None.

11. Estimate prepared by: Federal cost estimate: Mary Helen Petrus and Victoria Fraider; impact on State, local, and tribal Governments: Marc Nicole; impact on the private sector: Ellen Breslin Davidson.

12. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

Regulatory Impact Statement

In compliance with paragraph 11(b) of Rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact which would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any significant regulation of individuals or businesses or result in any significant impact on the personal privacy of any individuals, and that the paperwork resulting from enactment would be minimal.

Tabulation of Votes Cast in Committee

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by members of the Committee on Veterans' Affairs at its July 24, 1996, meeting. On that date, the Committee, by unanimous voice vote, ordered S. 1359 reported favorably to the Senate.

Agency Reports

Statement of Kenneth W. Kizer, M.D., M.P.H., Under Secretary for Health, Department of Veterans Affairs (May 11, 1995)

Mr. Chairman and Members of the Committee, I am pleased to have this opportunity to discuss with you my plan to restructure the Veterans Health Administration (VHA) as well as the proposal to amend Section 510 of Title 38.

As you know, copies of the plan, "Vision for Change," were sent to the Committee on March 17, 1995, in accordance with the current requirements of Section 510 of Title

38. In brief, the reorganization plan described in "Vision for Change" is designed to improve the delivery of health care to veterans, improve the quality of this care, increase the efficiency with which we provide it, and establish accountability for outcomes and bottom-line results. I would add that the reorganization plan is also designed to retain or continue those things in the system that are functioning well, as well as to complement our several statutory missions.

Perhaps the first issue I would comment on this morning is "why change VHA?" There are a number of reasons.

As a result of technological advances, economic factors, the restaff managed health care systems, and a variety of other forces, there have been profound changes in recent years in how health care is delivered in this country. There has been a marked shift away from inpatient care and a dramatic rise in ambulatory or outpatient care. For example, the majority of surgery is now performed on an outpatient basis. Likewise, chemotherapy for cancer is now routinely administered on an outpatient basis. Many complex medical conditions previously requiring hospitalization for intravenous antibiotics or other treatment are now routinely treated at home or in outpatient settings. And even more dramatic changes will occur in the years ahead. Indeed, it will not be that many years before the traditional general acute care hospital becomes a large ICU taking care of only the sickest and most complicated of patients. All other medical care will be provided in ambulatory care settings, at home, in hospices, or at various types of extended care facilities.

The VA must adapt to these changing conditions in the larger health care environment.

In addition, several reports on VA health care in recent years have concluded that structural changes are needed in the system. In the aggregate, these reports have consistently found that the VA needs to become more flexible, more customer-focused, more decentralized, and more cost-effective. Our plan to restructure the veterans health care system should accomplish all of these objectives.

Finally, for a variety of reasons, there has been a fundamental re-analysis of how government functions in recent years. The National Performance Review and other activities are being undertaken to reinvent government to minimize bureaucracy, to reward efficiency and innovation, and to empower employees to make government work better for citizens. While not undertaken as part of NPR, our plan for restructuring the VHA is consistent with its goals.

The foundation for accomplishing these changes in the veterans health care system involves the dissolution of the current hierarchical central office and regional office structure. In its place we will create a federation of Veterans Integrated Service Networks (VISN) that is supported by a national headquarters and other infrastructures. At this time, the plan calls for 22 VISNs, each including from five

to eleven medical centers and various other VA assets. VISN boundaries have been established in accordance with existing patient referral patterns; aggregations of patients and facilities needed to support primary, secondary, and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state lines.

It is envisioned that the VISN will become the basic budgetary and planning unit for delivering veterans health care. The individual and historically independent VA medical centers will remain important but less central components of larger, more community-based, interlocking networks of care.

As an integrated system of care, the new VISN structure will emphasize the pooling of resources, outpatient and primary care, partnerships and customer service. A premium will be placed on improved patient services, rigorous cost management, process improvement and outcomes. Emphasis will be placed on the integration of ambulatory care and acute and extended inpatient services to provide a coordinated continuum of care. Redundant administrative structures and processes will be eliminated. Each layer or process in the new organization will be expected to add value to the delivery of services.

Each VISN director will be assisted by a small staff of professional, technical, and support personnel, the number varying with the size and complexity of the individual network. While the specific numbers and types of employees will be left to the discretion of the director, each VISN management will be expected to include expertise in medical management, finance and budgeting, and planning. Medical management and operations management will be expected to work hand-in-hand to provide "best value" care.

Other areas of expertise may be needed in a VISN from time to time that would not warrant a full-time staff member or collateral assignment. It is expected that the VISN director will draw such expertise on an ad hoc basis from individual facilities within the network, from headquarters, or from the Support Service Centers.

Two other important components of the field reorganization also warrant comment. The first is the Support Service Centers (SSCs). During the transition from where we are now to the new organization, the SSCs will preserve the expertise available in the existing four regional offices in areas such as construction management, finance, planning, and quality assurance. They will ensure continuity of operations while the regions dissolve and the VISNs become operational.

Once the VISNs are fully operational and their support needs more clearly delineated, and recognizing the concomitant decentralization that will take place, the SSCs will provide support services as required. We expect they will serve primarily as roll-up, data collection, and tech-

nical support centers providing needed information for both the networks and VHA headquarters.

The second structure I would mention is the Management Assistance Councils (MACs), which are conceived to be formal structures to ensure input from VHA's internal and external stakeholders. The MACs will be composed of facility directors, chiefs of staff, nurse executives, union representatives and others from within each VISN. Likewise, MACs will contain external representatives from veterans service organizations, state and local government, academic affiliates, and private sector health care entities, all of whom will serve as consultants to the council. Each council, working in close concert with its external consultants, would formulate plans and recommendations to the VISN director. It is intended that these MACs will ensure that the needs of the patients, the community, and others are incorporated into the decision-making process.

Let me conclude my comments on the field reorganization with some comments on how we will achieve accountability in the more decentralized VHA system that this reorganization will create.

Concern about accountability led us to devote an entire chapter of our plan to performance measurement and systems monitoring. The cornerstone of the accountability system will be a performance contract between each VISN director and the Under Secretary's office. Each contract will cover three general areas: (1) system wide needs and tasks that all VISNs will be expected to complete; (2) VISN-specific service delivery and efficiency objectives directed by headquarters; and (3) VISN-specific objectives as developed by VISN management.

The key areas of focus for VHA performance measures will be patient satisfaction, ease of access, quality of care, and efficiency. Performance measures will focus on outcomes, than on processes. In order to compare our performance to that of the communities we reside in, we will emphasize performance measures that allow for comparison to national and local private sector measures, as well as comparison with current performance evaluation trends supported by the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

Performance contracts will also address the support of education and research, as these missions and our academic partnerships have been a major factor in VA's achieving excellence in patient care. The fourth mission, emergency preparedness, also will be included in the performance contract with each VISN director.

In summary, field units and senior managers will be held accountable for measurable improvements to the veterans health care system. The resulting efficiencies should allow VHA to invest in new ways of providing high quality, efficient ambulatory and inpatient care to better meet our veterans' needs and expectations.

Mr. Chairman, in an effort to move as expeditiously as possible we have begun to make preliminary plans for implementing the field reorganization, subject, of course, to compliance with the requirements of Section 510. We have established a coordinating committee to oversee the many activities that will be involved, and we have created six technically oriented work groups that will handle detailed actions for restructuring headquarters, activating the VISNs, developing performance measurements and executive performance contracts, planning employee education and training, improving resource allocation, and evaluating our information management needs and capabilities. The work group chairs had their first meeting here in Washington on April 27th and 28th. Work group members have been appointed, and several of the groups are having their first meetings this week. We understand that the 90 days in session provided to the Congress for review of our plan under Section 510 (unless earlier legislative approval is provided) will be completed in late July or early August of this year, depending upon the recess schedule of the Senate. We will have completed our planning and preparations for the reorganization before then, and should be ready to begin implementing the new organization by August 3.

In order for the field reorganization to be successful, and for the VISNs to be empowered to make appropriate operational decisions, headquarters must change its focus from micro-managing operations to the critical role of governing and leading the overall system. In recognition of the changes in patient care delivery patterns in the field, headquarters must be restructured to better support the new delivery paradigm.

The new headquarters will provide support for specific groups of patients or functions rather than advocacy for specific medical or technical disciplines. Offices will be organized by function or "product line," whenever possible, rather than by discipline. Headquarters must focus much greater attention on achieving system wide quality improvement and the consistency of quality. Likewise, headquarters must focus more on cost management and strategic planning.

To accomplish our headquarters restructuring, I anticipate a three-step process. First, the headquarters staff will be reorganized as outlined in Chapter 3 and Appendix 5 of our report. Next, the staff will identify those operational activities that can be decentralized to the field, and they will make the necessary changes to policy manuals and directives. Third, the new core values and behaviors associated with our "Patients First" philosophy will begin to become institutionalized so that the new VHA headquarters can provide the kind of leadership and direction the field will need in the future.

Importantly, a significant part of this process will be to identify new functions the headquarters should perform

that have not been done in the past due to an historically misplaced emphasis on operational business. As I mentioned earlier, among these will be a heightened emphasis on strategic planning, development of "clinical benchmarks" ("best practices"), quality improvement, and system wide information management.

This concludes my general overview of our plan to restructure the veterans health care system. I would now like to present agency views regarding whether the Congressional report-and-wait restrictions found in 38 U.S.C. §510, affecting certain VA administrative reorganizations, should be repealed.

As you know, section 510(b) prohibits any VA action to implement a covered field administrative reorganization until we have submitted a detailed plan and justification to our authorizing committees, and then waited for a "90-day period of continuous session of Congress." The waiting period normally is longer than 90 days and can extend from four to six months or longer, depending upon Congressional recesses or when during a session the report is submitted. Consequently, there is uncertainty as to when the period will expire, or even whether the planned VA reorganization will be permitted. VA nevertheless must prepare and plan to efficiently implement the changes on the assumption that the reorganization will be permitted. Personnel transfers, resource real locations and mission changes must be identified by this point. This activity, coupled with the considerable delay caused by section 510 causes a great deal of counterproductive uncertainty and anxiety among VA managers and staff. (Section 510(d) places similar report-and-wait restrictions, although with a shorter 30-day waiting period, on covered reorganizations within VA Central Office; we believe this provision should be repealed as well.)

These restrictions impose burdens on VA operations and detract from efforts to improve health care services for veterans. The burdens are felt by VA managers in terms of inefficiency, uncertainty, prolonged delays and employee anxiety—burdens which good managers seek to prevent or minimize. Therefore, as a VA manager, and on behalf of the Secretary, I ask for your help in removing these unnecessary burdens from all VA operations. I ask that you repeal those restrictions on the authority of the Secretary to reorganize which are contained in subsections (b) through (f) of 38 U.S.C. §510. The basic authority of the Secretary to organize and reorganize the Department, contained in subsection (a), should of course be retained.

We recognize that our authorizing committees have a legitimate need to be kept fully informed of significant VA reorganizations or other changes affecting VA programs. We intend to keep you fully informed. As in the past, we will continue to work closely with the Congress to provide information about any significant change affecting VA pro-

grams, including VA reorganizations, and answer any questions.

As I discussed earlier, one of the crucial features of our planned reorganization of VHA into VISNs or health care networks is to empower local management with as much authority as possible and to hold them responsible for measurable results, rather than to attempt to micromanage operations. This is consistent with the Administration's initiatives to "reinvent government" by giving managers more flexibility and fewer restrictions. The delays encountered by the report-and-wait provisions of section 510 are inconsistent with, and frustrate, the ability of local managers to meet their responsibilities in a timely manner.

Under the proposed reorganization, the focus of providing services to veteran beneficiaries is predicated upon the utilization of a multiple facility network, which permits the VISN Director to shift resources and personnel within that network. The Section 510(b) restrictions are incompatible with this concept, because they focus on the functions and FTEE of individual facilities.

Moreover, retention of section 510(b) requirements could result in inconsistent reporting from network to network. For example, VISNs with identical reorganization goals could be required to act differently because of section 510(b) requirements. A VISN with a large FTEE base may be able to effect change without a 15 percent triggering FTEE loss to an individual facility, while a VISN with a more modest FTEE base may, while attempting the identical reallocation of resources, trigger the 15 percent FTEE reduction which requires the report-and-wait period under Section 510.

In summary, we believe the requirements of section 510 (b) through (f) unduly burden efforts to provide health care services more efficiently and effectively, and we therefore request that they be repealed.

STATEMENT OF KENNETH W. KIZER, M.D., M.P.H., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS (OCTOBER 25, 1995)

Good morning Mr. Chairman and Members of the Committee.

I am pleased to be here this morning to present the Administration's views on seven pieces of legislation concerning the veterans health care system. The bills cover a range of subjects related to VA's provision of health care services. As you know, six of the seven bills were considered, in one form or another, during the last Congress. As such, they were developed to address a different VA operational environment than exists today.

As a preface to my further comments I should note at the outset that any cost estimates provided in this testimony represent the best estimates available to us at this

time and are provided to assist the committee in its deliberations. They do not, however, represent official Administration estimates.

Now turning to the proposed legislation.

The one new measure before the Committee is, of course, your bill Mr. Chairman, which would provide VA with greater authority to share health care resources with community health care providers. I will address that bill first.

Draft bill—health-care resources sharing

In a word, Mr. Chairman, we strongly support your draft bill, which we understand will be known as the Veterans Health Care Management and Contracting Act of 1995.

Earlier this fall, we sent to Congress a legislative proposal that contained provisions similar to those contained in this bill. At that time, we stated that today's health care environment demands that all types of providers cooperate and work together. The VA health care system is an integral part of the larger health care community, and the VA must be able to work with partners in both the private and public sectors. Unfortunately, current law limits our ability to obtain needed health care resources for veterans, and share our resources with others in the community. Your draft bill would remedy this problem.

Currently VA may obtain only "specialized medical resources" under sharing authority. The term "specialized medical resource" is limited to medical resources which because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to optimal utilization only through mutual use. VA may enter into sharing agreements with only "health care facilities (generic for hospital), research centers, or medical schools," as well as certain state veteran homes.

Your bill would amend existing law to permit the Department to share all types of health care resources with all types of health care providers. It would define "health care resource" to include conventional health care services such as hospital care, nursing home care, outpatient care, rehabilitative care, and preventive care. Additionally, it would include other health care support or administrative services essential to the operation of a health care system.

The draft bill would also more broadly define the term "health care provider" to include insurers, health care plans, group practices, health care management organizations, and individuals such as physicians or other solo providers. This would benefit the VA in many ways and probably especially so in rural areas.

A second provision in your bill would permanently eliminate certain provisions in title 38 which limit our ability to contract for health and health-related services. Last year, in Public Law 103–446, Congress suspended for five fiscal years the application of those limitations, which are found at 38 U.S.C. §8110(c). Permanently eliminating the

restrictions is consistent with the expanded sharing authority which your bill provides.

As a final matter, your bill would ease title 38, section 510, restrictions on the Department's ability to reorganize itself. Current statute requires the Department to provide Congress with advance notice of any administrative reorganization realigning functions and affecting more than 10 percent of employees. After reporting a proposed reorganization, we can take no action to implement it until a "90-day continuous session of Congress" waiting period expires. Your bill would amend the law to permit us to begin implementation 45 calendar days after we submit our report to Congress. We support this proposed change.

The present waiting period is an onerous and unnecessary requirement. It is too long. The law provides that House or Senate recesses for four days or longer don't count. As a result, the waiting period typically will last for five to six months. The exact length of the waiting period is difficult to predict, and is subject to change up to the last minute because of changes in House or Senate recesses. This waiting period does not enable us to respond quickly to changes in the health care environment or to prepare to implement reorganizations on a precise timetable.

The recent history of our VISN reorganization is a good example. We provided Congress with the required report for that reorganization on March 17, 1995, but the "90 day" waiting period did not end until September 5, 1995. Indeed, the House went into recess on the 89th day of the 90 day waiting period, requiring that we delay implementation for an additional six weeks until the House came back into session. Your 45 calendar day proposal would provide a sufficient time for Congressional review without unduly delaying managerial improvements.

S. 293—Adult day health care in State homes

S. 293, introduced by Senator Conrad, would enhance the ability of States to offer adult day health care programs in State veteran homes. The bill would authorize us to pay states per diem (at a rate to be determined by the Secretary) for veterans who receive such care in a State Home. It would also authorize construction grants to states for use in developing facilities to furnish such care. As now configured, State Veterans Homes provide hospital, nursing home, and domiciliary care in facilities owned and operated by the states. VA contributes toward the cost of constructing and renovating the facilities through a grant program, and also helps pay operational costs by paying states a per diem for veterans living in the facility.

Adult day health care generally refers to the provision of health care services in a congregate setting during day time hours. Adult day health care meets the needs of a

very specific population. It is not a substitute for all types of nursing home care.

In FY 1991, VA completed and transmitted a study to Congress of the adult day health care service in VA and community settings. The study concluded that these services are popular with patients and their families, but can be more expensive than other outpatient alternatives such as Hospital Based Home Care. Despite this, potential cost concern, we believe adult day health care should be an option for carefully selected veterans.

We estimate that there would be no cost for this provision of the bill in the first year while it is being implemented. It is conceivable that the five year cost might be as much as $4.4 million; however, if properly managed, we believe that use of this treatment option would be budget neutral.

S. 425—Mental illness research, education, and clinical care centers

S. 425, introduced by Mr. Rockefeller, calls for the Department to establish and operate up to five VA health care facilities as centers for mental illness research, education, and clinical care. These centers are often referred to as MIRECC's, and they are patterned after VA's Geriatric Research, Education and Clinical Centers, which are known as GRECC's.

As I believe representatives of the Department have stated in the past, it is the Department's view that we could establish MIRECC's without enactment of this legislation. Indeed, the Mental Health and Behavioral Sciences Service is currently drafting an RFP to establish up to five MIRECC's, depending on resource availability within the current appropriation.

In addition to this, I would also note that we are currently reviewing the entire research program to better focus on the needs of veterans and to ensure optimal use of taxpayer dollars. Insofar as the MIRECC concept was proposed several years ago as a means of enhancing research on mental illness, this approach may not be the most effective means of achieving these goals today. We believe decisions on research strategy should be left to research managers who consider funding availability and competing priorities when determining the best approach to meet the mental health research needs of veterans.

We estimate the costs of this measure would be the amounts authorized in the bill, which are $3.125 million for fiscal year 1996, and $6.25 million over each of fiscal years 1997 through 1999.

S. 612—Hospice care program

S. 625, introduced by Senator Rockefeller, would direct the Secretary to undertake two different projects to furnish hospice care to terminally ill veterans. The first project would be a five-year pilot program to determine the fea-

sibility and desirability of furnishing such services. It would require that we furnish complete hospice care services at between 15 and 30 medical centers using three different mechanisms, including direct VA care and contract care. The second project would require that VA furnish much more limited palliative care to veterans, both directly and through contracting. We would have to evaluate both projects continuously and report annually to the Congress regarding the evaluations.

Over two years ago, my predecessor provided testimony before this committee on a bill substantially the same as that being considered today. He stated that the Department strongly supports providing hospice care for terminally ill veterans as an effective and humane way to care for those who choose it. He further indicated that VHA has in recent years established excellent programs for the terminally ill, negating the need for additional legislation. Today, I echo my predecessor in saying that care for the terminally ill is a critical component of providing complete health care service. We continue to believe that the proposed legislation is unnecessary and that resources to carry out an evaluative study of the various means of providing hospice services would be better used to enhance those programs we now operate.

Having said this, I should briefly describe VA's hospice programs. Hospice actually refers to how one delivers care to the terminally ill patient, instead of a type of facility. Every medical center in our system has in place a hospice consultation team, which is the essence of the program. The consultation team exists to make certain that the patient receives "hospice care." The team includes, at a minimum, a physician, a nurse, a social worker, and a chaplain. Each team consults with the patient's primary care team on pain management and other care issues. Additionally, the team is responsible for advising hospital management on policies and procedures related to provision of hospice and palliative care. Each team develops and maintains expertise in the clinical care of the terminally ill patient, and in the ethical issues involved in the care of the dying patient. Finally, the team keeps abreast of developments in Medicare and Medicaid hospice programs, as well as local community hospice programs.

Some VA medical centers operate specially designated inpatient wards devoted exclusively to caring for the terminally ill. The decision whether to operate such an inpatient unit is left to individual medical center management and is somewhat dependent on bed availability.

Hospice care is also provided to some veterans through community-based home hospice care providers. In cases where veterans are eligible for contract care, VA purchases the care for them. Additionally, veterans over the age of sixty-five are ordinarily eligible for Medicare benefits. When home hospice care is available through Medicare ap-

proved programs, our medical centers refer patients to those programs.

S. 548—Mammography standards

Three years ago, Congress enacted the Mammography Quality Standards Act of 1992, which requires providers to comply with accreditation and other standards issued by the Department of Health and Human Services for mammography equipment, personnel, and quality assurance. VA facilities were expressly excluded from coverage under the statute. S. 548, also introduced by Senator Rockefeller, would compel VA to establish mammography standards that, at a minimum, meet HHS (FDA) standards. We compliment Senator Rockefeller for his advocacy on this issue.

Likewise, I am sure you all will be pleased to know that VA policy now requires compliance with the requirements of the 1992 Mammography Quality Standards Act. Moreover, all VA facilities furnishing mammography services are currently using the FDA's guidelines. Twenty-eight (28) of VA's 43 mammography programs are now fully accredited by the American College of Radiology. The remaining 15 have obtained provisional accreditation, and within four to six months will receive full ACR accreditation. As for contract providers, VA obtains mammography services only from FDA certified mammography facilities. Indeed, VA issued formal policy to this effect on July 11, 1995, thus formalizing existing practice in the Veterans Health Administration.

In sum, thus, VA already has a mammography program in place that accomplishes what this bill seeks to do, and the proposed legislation is not needed.

S. 644—Research Corporations

S. 644, introduced by Senator Campbell, would reestablish authority for VA to establish nonprofit research corporations at VA medical centers.

Congress first authorized VA to establish nonprofit research corporations in 1988, but directed that all corporations be established by September 30, 1991. That date was subsequently extended to December 31, 1992. Corporations were established in 79 locations—i.e., at almost half of all VA medical centers. They were established at essentially all large, highly affiliated VA centers having sophisticated research programs. The corporations are able to obtain gifts, grants or contracts from non-VA public and private entities to support VA-approved research at VA medical facilities. In most cases, the corporations provide a benefit to VA's research program without representing any additional costs to VA.

Despite the value of the existing research corporations, there is no compelling need, at this time, to establish research corporations at the remaining, mostly smaller, rural VA medical centers.

As I noted earlier, we are not only engaged in a major reorganization of the veterans' medical system, but we are also reviewing the entire research program as well. After this review is done we would be in a better position to determine whether more of these entities are needed.

In addition, we have just published national policy for the operation of VA nonprofit research corporations which includes guidance for administering, budgeting, and oversight of these corporations. We would like to see the efficiencies resulting from these guidelines before creating new organizations.

S. 403—Readjustment counseling

S. 403, introduced by Senator Akaka, contains a number of different provisions affecting the Readjustment Counseling Service, and the Vet Centers through which we provide readjustment counseling services.

Section 2 of the bill would preserve the existing organizational and administrative structure of the Readjustment Counseling Service by statutorily mandating that structure. It would permit alteration of the structure only after providing the Veterans' Affairs Committees with 60 days advance notice of the proposed changes. Finally, the section would require that each year, the President's Budget must specifically state the amount requested for readjustment counseling, including the amount requested to fund the Advisory Committee on the Readjustment of Veterans.

As you know, VHA is now implementing a major reorganization, and we have determined that the organization and structure of the Readjustment Counseling Service should not be changed, since it appears to be working well at this time. Since any change to this structure already requires Congressional review and approval, we can see no advantage to statutorily locking in that structure. If at some point in time we determine that the organization does need change, we will, of course, work with the Congress, Veterans Service Organizations, and other interested parties to make certain those plans are in the best interests of the program. I would also point out that each year in the President's Budget, we identify the amount requested for the Readjustment Counseling Service, so it is unnecessary to add another law requiring what is already done.

Section 3 of the bill would elevate the position of the Director of the Readjustment Counseling Service to that of an Assistant Under Secretary for Health. We do not support this provision. Earlier this year we sent a bill to Congress which would delete statutory requirements that we have discipline specific services and positions. We are seeking those changes so we may have the flexibility to determine which office and position in the organization can best provide management direction for particular functions. We intend to retain the position of Director of the Readjustment Counseling Service. However, to statutorily

require that position, as proposed in this bill, would be inconsistent with our effort to remove these unnecessary requirements.

Section 4 of the bill would revise eligibility for readjustment counseling services. It would provide that VA "shall" furnish services to those now eligible, and to all other veterans who served in a combat theater during a period of war or other hostilities. It would provide that VA "may" furnish readjustment counseling to all other veterans. The law currently authorizes us to provide those services only to Vietnam era veterans, and veterans who served in the Persian Gulf, Lebanon, Panama, and Grenada.

The Administration supports extending these services to wartime veterans who served in areas of conflict, particularly those who served in World War II and Korea. We anticipate being able to provide these services within existing appropriations. However, we do not believe we can afford to expand the program to all veterans at this time.

Since their inception in 1979, the Vet Centers have primarily addressed the needs of veterans who served in war zones, and although all Vietnam Era veterans are eligible for services, most demand has been from those who actually served in Vietnam. Over the years, eligibility has been extended to others who served in the Persian Gulf, Panama, Grenada, and Lebanon. The focus of the program on war zone veterans recognizes the special readjustment needs those individuals have, including treatment of posttraumatic stress disorder resulting from combat. That focus has also served to distinguish Vet Centers, and make them unique from other mental health clinics which seek to meet the needs of a wider population.

To provide all veterans with discretionary eligibility for readjustment counseling services might raise the expectations of those veterans that they might be able to receive services which VA is unlikely to be funded for. Moreover, providing services to all veterans could fundamentally change the nature of the Vet Centers and their counseling program. In the Department's view, veterans who served in combat are deserving of the special attention that the Readjustment Counseling Service now provides, and we should not compromise that program by trying to meet the broader counseling needs of the entire veteran population. Section 4 would also authorize Vet Centers to provide bereavement counseling. The bill would require that VA furnish such counseling to the families of all veterans who died in combat. It would permit counseling for families of those who are on active duty, or who die as a result of a service connected disability.

The Administration supports a limited bereavement counseling role for the families of those who died in combat. This would be affordable, and it would be in keeping with the nature of Vet Centers as entities serving the specific needs of those who served in war. Again, we believe

we can provide these services within existing appropriations.

Section 5 of the bill would statutorily establish an Advisory Committee on Readjustment Counseling. In essence, it would provide a statutory mandate for the Department's current Advisory Committee on the Readjustment of Vietnam and Other War Veterans. The section would provide that members of the current committee would become members of the new committee. The bill contains many detailed provisions pertaining to the membership on the committee, its operation, and its functions. This provision is unnecessary.

Section 6 would require that we prepare and submit to this committee, and its counterpart in the House, a plan for converting all Vet Centers into Vietnam Veteran Resource Centers. The plan must contain a timetable for this effort.

Several years ago, at the direction of Congress, VA undertook a pilot program in several Vet Centers to provide additional services to those eligible for readjustment counseling. These resource centers provide benefits counseling; employment counseling, training and placement; intake and referral services for veterans needing substance abuse treatment; and general coordination of benefits. Whether to expand the resource center concept throughout the system is a matter that should be left to our planning processes. We see no need at this time to direct limited resources to the development of a plan to expand resource centers.

Section 7 would require VA to submit a report to Congress on the feasibility and desirability of collocation of Vet Centers and outpatient clinics.

Section 8 would direct that we carry out a two-year pilot program to provide veterans with outpatient medical services at Vet Centers. The bill directs that 10 Vet Centers in diverse locations serve as sites for furnishing veterans with basic ambulatory services and health care screening. The bill also calls for a report to Congress at the conclusion of the pilot program.

Providing basic health care services in Vet Centers would fundamentally change the unique nature of these facilities. Much of the success these entities have experienced over the years is attributed to their not being outpatient clinics providing routine medical services. The centers are places where veterans who have suffered the psychological ravages of war can find assistance from counselors who often have had similar experiences. Experts in the field advise that introducing basic medical care services into the mix of services now provided by Vet Centers would compromise the continued success of these facilities.

Notwithstanding the above, we already have the authority which would permit us to furnish outpatient medical services through Vet Centers. In some locations Vet Centers are, in fact, located side-by-side with clinics providing

outpatient care. However, those are unique situations, and the facilities are carefully tailored to make certain that the Vet Center maintains its nature as a counseling center, not a medical clinic. But the point is that local VA managers currently have all the authority needed to co-locate these activities when it is desirable based on local circumstances.

We have not had time to estimate the costs of this legislation, but we believe costs would exceed the estimate we made two years ago of $236 million over five fiscal years.

Mr. Chairman, this concludes my formal testimony. I would be pleased to answer any questions.

STATEMENT OF CHARLES L. CRAGIN, CHAIRMAN, BOARD OF VETERANS' APPEALS, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee:

I am pleased to be here today to present the views of the Department of Veterans Affairs (VA) on several bills. Those bills are:

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S. 1750, a bill to modify disbursement agreement authority to include residents and interns serving in any VA facility providing hospital care or medical services;

* * * * * * *

S. 1752, a bill to exempt full-time registered nurses, physician assistants, and expanded-function dental auxiliaries from restriction on remunerated outside professional activities; and

S. 1753, a bill to suspend a special pay agreement for physicians and dentists who enter residency training programs.

* * * * * * *

S. 1750

This bill would expand VA's authority to enter into disbursement agreements with participating medical institutions for the central administration of pay and other employee benefits for residents and interns who train at VA facilities. Currently, the law authorizes the use of such agreements only for residents and interns serving in VA hospitals but not those serving in outpatient clinics, nursing homes, or other VA medical facilities. VA requested this legislation to allow VA health care facilities which are not hospitals but are nonetheless increasingly important components of the VA health-care delivery system to participate in the cost saving and other benefits provided by disbursement agreements.

* * * * * * *

S. 1752

This bill would exempt VHA full-time registered nurses (RNs), physician assistants (PAs), and expanded-function dental auxiliaries (EFDAs) from the restriction on moonlighting applicable to all title 38 employees. VA requested this legislation because the current restrictions on moonlighting for these employees is outdated. Removal of these restrictions on an employee's use of personal time will allow VA to be more competitive with employers who impose no such restriction. The original purpose of the outside-professional-activities restrictions was to ensure the availability of health care professionals who are responsible for around-the-clock care of VA patients. VA has considerable flexibility to ensure coverage of these three professions and no longer uses this authority to provide coverage.

S. 1753

S. 1753 would authorize VA to suspend the special pay agreement of a physician or dentist who enters a residency training program, whether VA-sponsored or not. Currently, a VA physician or dentist (receiving special pay pursuant to a special pay agreement) who enters a residency training program must convert to a special appointment category that is excluded from receiving special pay. Thus, a VA physician who is receiving special pay cannot accept a residency training position or enter a non-VA sponsored residency prior to the expiration of the special pay agreement without breaching his or her agreement and triggering an obligation to repay the special pay received in that year. VA requested enactment of this bill to remove adverse financial consequences for those who wish to enter residency training programs to increase and develop their professional knowledge and skills. The bill waives the repayment requirement for staff who return to VA after their training is complete.

This concludes my statement, Mr. Chairman. I would be pleased to answer any questions that you or the members of the Committee may have.

CHANGES IN EXISTING LAW MADE BY S. 1359 AS REPORTED

In compliance with paragraph 12 of Rule XXVI of the Standing Rules of the Senate, changes in existing law made by the Committee bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38—VETERANS' BENEFITS

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PART I—GENERAL PROVISIONS

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CHAPTER 5—AUTHORITY AND DUTIES OF THE SECRETARY

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Subchapter III—Advisory Committees

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§ 510. Authority to reorganize offices

(a) * * *

(b) The Secretary may not in any fiscal year implement an administrative reorganization described in subsection (c) unless the Secretary first submits to the appropriate committees of the Congress a report containing a detailed plan and justification for the administrative reorganization. No action to carry out such reorganization may be taken after the submission of such report until the end of a [90-day period of continuous session of Congress following] 45-day period (30 days of which shall be days during which Congress shall have been in continuous session) beginning on the date of the submission of the report. For purposes of the preceding sentence, continuity of a session of Congress is broken only by adjournment sine die, and there shall be excluded from the computation of such 90-day period any day during which either House of Congress is not in session during an adjournment of more than three days to a day certain.

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Subchapter III—Advisory Committees

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§ 545. Advisory Committee on the Readjustment of Veterans

(a)(1) There is in the Department the Advisory Committee on the Readjustment of Veterans (hereinafter in this section referred to as the "Committee").

(2) The Committee shall consist of not more than 18 members appointed by the Secretary from among individuals who—

(A) have demonstrated significant civic or professional achievement; and

(B) have experience with the provision of veterans benefits and services by the Department.

(3) The Secretary shall seek to ensure that members appointed to the Committee include individuals from a wide variety of geographic areas and ethnic backgrounds, individuals from veterans service organizations, individuals with combat experience, and women.

(4) The Secretary shall determine the terms of service and pay and allowances of the members of the Committee, except that a term of service may not exceed 2 years. The Secretary may reappoint any member for additional terms of service.

(b)(1) The Secretary shall, on a regular basis, consult with and seek the advice of the Committee with respect to the provision by the Department of benefits and services to veterans in order to assist veterans in the readjustment to civilian life.

(2)(A) In providing advice to the Secretary under this subsection, the Committee shall—

(i) assemble and review information relating to the needs of veterans in readjusting to civilian life;

(ii) provide information relating to the nature and character of psychological problems arising from service in the Armed Forces;

(iii) provide an on-going assessment of the effectiveness of the policies, organizational structures, and services of the Department in assisting veterans in readjusting to civilian life; and

(iv) provide on-going advice on the most appropriate means of responding to the readjustment needs of veterans in the future.

(B) In carrying out its duties under subparagraph (A), the Committee shall take into special account the needs of veterans who have served in a theater of combat operations.

(c)(1) Not later than March 31 of each year, the Committee shall submit to the Secretary a report on the programs and activities of the Department that relate to the readjustment of veterans to civilian life. Each such report shall include—

(A) an assessment of the needs of veterans with respect to readjustment to civilian life;

(B) a review of the programs and activities of the Department designed to meet such needs; and

(C) such recommendations (including recommendations for administrative and legislative action) as the Committee considers appropriate.

(2) Not later than 90 days after the receipt of a report under paragraph (1), the Secretary shall transmit to the Committees on Veterans' Affairs of the Senate and House of Representatives a copy of the report, together with any comments and recommendations concerning the report that the Secretary considers appropriate.

(3) The Committee may also submit to the Secretary such other reports and recommendations as the Committee considers appropriate.

(4) The Secretary shall submit with each annual report submitted to the Congress pursuant to section 529 of this title a summary of all reports and recommendations of the Committee submitted to the Secretary since the previous annual report of the Secretary submitted pursuant to that section.

(d)(1) Except as provided in paragraph (2), the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the activities of the Committee under this section.

(2) Section 14 of such Act shall not apply to the Committee.

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PART II—GENERAL BENEFITS

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CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

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Subchapter VII—Hospice Care Pilot Program; Hospice Care Services

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Subchapter II—Hospital, Nursing Home, or Domiciliary Care and Medical Treatment

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§ 1712A. Eligibility for readjustment counseling and related mental health services

[(a)(1) Upon the request of any veteran who served on active duty during the Vietnam era, the Secretary shall, within the limits of Department facilities, furnish counseling to such veteran to assist such veteran in readjusting to civilian life. Such counseling shall include a general mental and psychological assessment to ascertain whether such veteran has mental or psychological problems associated with readjustment to civilian life.

[(2)(A) The Secretary shall furnish counseling as described in paragraph (1), upon request, to any veteran who served on active duty after May 7, 1975, in an area at a time during which hostilities occurred in such area.

[(B) For the purposes of subparagraph (A) of this paragraph, the term "hostilities" means an armed conflict in which members of the Armed Forces are subjected to danger comparable to the danger to which members of the Armed Forces have been subjected in combat with enemy armed forces during a period of war, as determined by the Secretary in consultation with the Secretary of Defense.]

(a)(1)(A) Upon the request of any veteran referred to in subparagraph (B) of this paragraph, the Secretary shall furnish counseling to the veteran to assist the veteran in readjusting to civilian life.

(B) Subparagraph (A) applies to the following veterans:

(i) Any veteran who served on active duty in a theater of combat operations (as determined by the Secretary in consultation with the Secretary of Defense) during the Vietnam era.

(ii) Any veteran who served on active duty during the Vietnam era if the veteran seeks such counseling before January 1, 2000.

(iii) Any veteran referred to in clause (ii) of this subparagraph if the veteran is furnished counseling under this subsection before the date referred to in that clause.

(iv) Any veteran who served on active military, naval, or air service in a theater of combat operations (as so determined) during a period of war, or in any other area during a period in which hostilities (as defined in subparagraph (D) of this paragraph) occurred in such area.

(C) Upon the request of any veteran other than a veteran covered by subparagraph (A) of this paragraph, the Secretary may furnish counseling to the veteran to assist the veteran in readjusting to civilian life.

(D) For the purposes of subparagraph (B) of this paragraph, the term "hostilities" means an armed conflict in which the members of the Armed Forces are subjected to danger comparable to the danger to which members of the Armed Forces have been subjected in combat with enemy armed forces during a period of war, as determined by the Secretary in consultation with the Secretary of Defense.

(2) The counseling referred to in paragraph (1) of this subsection shall include a general mental and psychological assessment of a covered veteran to ascertain whether such veteran has mental or psychological problems associated with readjustment to civilian life.

(b)(1) * * *

* * * * * * *

[(c) Upon receipt of a request for counseling under this section from any individual who has been discharged or released from active military, naval, or air service but who is not eligible for such counseling, the Secretary shall—

[(1) provide referral services to assist such individual, to the maximum extent practicable, in obtaining mental health care and services from sources outside the Department; and

[(2) if pertinent, advise such individual of such individual's rights to apply to the appropriate military, naval, or air service and the Department for review of such individual's discharge or release from such service.]

(c)(1) The Secretary shall provide the counseling services described in section 1701(6)(B)(ii) of this title to the surviving parents, spouse, and children of any member of the Armed Forces who dies—

(A) in a theater of combat operations (as determined by the Secretary in consultation with the Secretary of Defense) while on active military, naval, or air service during a period of war;

(B) in an area in which hostilities (as defined in subsection (a)(1)(D) of this section) are occurring while on such service during such hostilities;

(C) as a result of a disease, injury, or condition incurred while on such service in a theater of combat operations (as so determined)

(2) The Secretary may provide the counseling services referred to in paragraph (1) of this subsection to the surviving parents, spouse, and children of any member of the Armed Forces who dies while serving on active duty or from a condition (as determined by the Secretary) incurred in or aggravated by such service.

(d) * * *

(e)(1) In furnishing counseling and related mental health services under [subsections (a) and (b)] *subsections (a), (b), and (c)* of this section, the Secretary shall have available the same authority to enter into contracts with private facilities that is available to the

Secretary (under sections 1712(a)(1)(B) and 1703(a)(2) of this title) in furnishing medical services to veterans suffering from total service-connected disabilities.

(2) Before furnishing counseling or related mental health services described in [subsections (a) and (b)] *subsections (a), (b), and (c)* of this section through a contract facility, as authorized by this subsection, the Secretary shall approve (in accordance with criteria which the Secretary shall prescribe by regulation) the quality and effectiveness of the program operated by such facility for the purpose for which the counseling or services are to be furnished.

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Subchapter V—Payments to State Homes

§ 1741. Criteria for payment

(a)*(1)* The Secretary shall pay each State at the per diem rate of—

[(1)] *(A)* $8.70 for domiciliary care; and

[(2)] *(B)* $20.35 for nursing home care and hospital care, for each veteran receiving such care in a State home, if such veteran is eligible for such care in a Department facility.

(2) The Secretary may pay each State per diem at a rate determined by the Secretary for each veteran receiving adult day health care in a State home, if such veteran is eligible for such care under laws administered by the Secretary.

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Subchapter VII—Hospice Care Pilot Program; Hospice Care Services

§ 1761. Definitions

For the purposes of this subchapter—

(1) The term "terminally ill veteran" means any veteran—

(A) who is (i) entitled to receive hospital care in a medical facility of the Department under section 1710(a)(1) of this title, (ii) eligible for hospital or nursing home care in such a facility and receiving such care, (iii) receiving care in a State home facility for which care the Secretary is paying per diem under section 1741 of this title, or (iv) transferred to a non-Department nursing home for nursing home care under section 1720 of this title and receiving such care; and

(B) who has a medical prognosis (as certified by a Department physician) of a life expectancy of six months or less.

(2) The term "hospice care services" means—

(A) the care, items, and services referred to in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)); and

(B) personal care services.

(3) The term "hospice program" means any program that satisfies the requirements of section 1861(dd)(2) of the Social Security Act (42 U.S.C. 1395x(dd)(2)).

(4) The term "medical facility of the Department" means a facility referred to in section 1701(3)(A) of this title.

(5) The term "non-Department facility" means a facility (other than a medical facility of the Department) at which care to terminally ill veterans is furnished, regardless of whether such care is furnished pursuant to a contract, agreement, or other arrangement referred to in section 1762(b)(1)(D) of this title.

(6) The term "personal care services" means any care or service furnished to a person that is necessary to maintain a person's health and safety within the home or nursing home of the person, including care or services related to dressing and personal hygiene, feeding and nutrition, and environmental support.

§ 1762. Hospice care: pilot program requirements

(a)(1) During the period beginning on October 1, 1996, and ending on December 31, 2001, the Secretary shall conduct a pilot program in order—

(A) to assess the desirability of furnishing hospice care services to terminally ill veterans; and

(B) to determine the most effective and efficient means of furnishing such services to such veterans.

(2) The Secretary shall conduct the pilot program in accordance with this section.

(b)(1) Under the pilot program, the Secretary shall—

(A) designate not less than 15 nor more than 30 medical facilities of the Department at or through which to conduct hospice care services demonstration projects;

(B) designate the means by which hospice care services shall be provided to terminally ill veterans under each demonstration project pursuant to subsection (c);

(C) allocate such personnel and other resources of the Department as the Secretary considers necessary to ensure that services are provided to terminally ill veterans by the designated means under each demonstration project; and

(D) enter into any contract, agreement, or other arrangement that the Secretary considers necessary to ensure the provision of such services by the designated means under each such project.

(2) In carrying out the responsibilities referred to in paragraph (1) the Secretary shall take into account the need to provide for and conduct the demonstration projects so as to provide the Secretary with such information as is necessary for the Secretary to evaluate and assess the furnishing of hospice care services to terminally ill veterans by a variety of means and in a variety of circumstances.

(3) In carrying out the requirement described in paragraph (2), the Secretary shall, to the maximum extent feasible, ensure that—

(A) the medical facilities of the Department selected to conduct demonstration projects under the pilot program include facilities located in urban areas of the United States and rural areas of the United States;

(B) the full range of affiliations between medical facilities of the Department and medical schools is represented by the facilities selected to conduct demonstration projects under the pilot

program, including no affiliation, minimal affiliation, and extensive affiliation;

(C) such facilities vary in the number of beds that they operate and maintain; and

(D) the demonstration projects are located or conducted in accordance with any other criteria or standards that the Secretary considers relevant or necessary to furnish and to evaluate and assess fully the furnishing of hospice care services to terminally ill veterans.

(c)(1) Subject to paragraph (2), hospice care to terminally ill veterans shall be furnished under a demonstration project by one or more of the following means designated by the Secretary:

(A) By the personnel of a medical facility of the Department providing hospice care services pursuant to a hospice program established by the Secretary at that facility.

(B) By a hospice program providing hospice care services under a contract with that program and pursuant to which contract any necessary inpatient services are provided at a medical facility of the Department.

(C) By a hospice program providing hospice care services under a contract with that program and pursuant to which contract any necessary inpatient services are provided at a non-Department medical facility.

(2)(A) The Secretary shall provide that—

(i) care is furnished by the means described in paragraph (1)(A) at not less than five medical facilities of the Department; and

(ii) care is furnished by the means described in subparagraphs (B) and (C) of paragraph (1) in connection with not less than five such facilities for each such means.

(B) The Secretary shall provide in any contract under subparagraph (B) or (C) of paragraph (1) that inpatient care may be provided to terminally ill veterans at a medical facility other than that designated in the contract if the provision of such care at such other facility is necessary under the circumstances.

(d)(1) Except as provided in paragraph (2), the amount paid to a hospice program for care furnished pursuant to subparagraph (B) or (C) of subsection (c)(1) may not exceed the amount that would be paid to that program for such care under section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) if such care were hospice care for which payment would be made under part A of title XVIII of such Act.

(2) The Secretary may pay an amount in excess of the amount referred to in paragraph (1) (or furnish services whose value, together with any payment by the Secretary, exceeds such amount) to a hospice program for furnishing care to a terminally ill veteran pursuant to subparagraph (B) or (C) of subsection (c)(1) if the Secretary determines, on a case-by-case basis, that—

(A) the furnishing of such care to the veteran is necessary and appropriate; and

(B) the amount that would be paid to that program under section 1814(i) of the Social Security Act would not compensate the program for the cost of furnishing such care.

§ 1763. Care for terminally ill veterans

(a) During the period referred to in section 1762(a)(1) of this title, the Secretary shall designate not less than 10 medical facilities of the Department at which hospital care is being furnished to terminally ill veterans in order to furnish the care referred to in subsection (b)(1).

(b)(1) Palliative care to terminally ill veterans shall be furnished at the facilities referred to in subsection (a) by one of the following means designated by the Secretary:

(A) By personnel of the Department providing one or more hospice care services to such veterans at or through medical facilities of the Department.

(B) By personnel of the Department monitoring the furnishing of one or more of such services to such veterans at or through non-Department facilities.

(2) The Secretary shall furnish care by the means referred to in each of subparagraphs (A) and (B) of paragraph (1) at not less than five medical facilities designated under subsection (a).

§ 1764. Information relating to hospice care services

The Secretary shall ensure to the extent practicable that terminally ill veterans who have been informed of their medical prognosis receive information relating to the eligibility, if any, of such veterans for hospice care and services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

§ 1765. Evaluation and reports

(a) Not later than September 30, 1997, and on an annual basis thereafter until October 1, 2002, the Secretary shall submit a written report to the Committees on Veterans' Affairs of the Senate and House of Representatives relating to the conduct of the pilot program under section 1762 of this title and the furnishing of hospice care services under section 1763 of this title. Each report shall include the following information:

(1) The location of the sites of the demonstration projects provided for under the pilot program.

(2) The location of the medical facilities of the Department at or through which hospice care services are being furnished under section 1763 of this title.

(3) The means by which care to terminally ill veterans is being furnished under each such project and at or through each such facility.

(4) The number of veterans being furnished such care under each such project and at or through each such facility.

(5) An assessment by the Secretary of any difficulties in furnishing such care and the actions taken to resolve such difficulties.

(b) Not later than August 1, 2000, the Secretary shall submit to the committees referred to in subsection (a) a report containing an evaluation and assessment by the Under Secretary for Health of the hospice care pilot program under section 1762 of this title and the furnishing of hospice care services under section 1763 of this title. The report shall contain such information (and shall be presented in such form) as will enable the committees to evaluate fully the de-

sirability of furnishing hospice care services to terminally ill veterans.

(c) The report under subsection (b) shall include the following:

(1) A description and summary of the pilot program.

(2) With respect to each demonstration project conducted under the pilot program—

(A) a description and summary of the project;

(B) a description of the facility conducting the demonstration project and a discussion of how such facility was selected in accordance with the criteria set out in, or prescribed by the Secretary pursuant to, subparagraphs (A) through (D) of section 1762(b)(3) of this title;

(C) the means by which hospice care services care are being furnished to terminally ill veterans under the demonstration project;

(D) the personnel used to furnish such services under the demonstration project;

(E) a detailed factual analysis with respect to the furnishing of such services, including (i) the number of veterans being furnished such services, (ii) the number, if any, of inpatient admissions for each veteran being furnished such services and the length of stay for each such admission, (iii) the number, if any, of outpatient visits for each such veteran, and (iv) the number, if any, of home-care visits provided to each such veteran;

(F) the direct costs, if any, incurred by terminally ill veterans, the members of the families of such veterans, and other individuals in close relationships with such veterans in connection with the participation of veterans in the demonstration project;

(G) the costs incurred by the Department in conducting the demonstration project, including an analysis of the costs, if any, of the demonstration project that are attributable to (i) furnishing such services in facilities of the Department, (ii) furnishing such services in non-Department facilities, and (iii) administering the furnishing of such services; and

(H) the unreimbursed costs, if any, incurred by any other entity in furnishing services to terminally ill veterans under the project pursuant to section 1762(c)(1)(C) of this title.

(3) An analysis of the level of the following persons' satisfaction with the services furnished to terminally ill veterans under each demonstration project:

(A) Terminally ill veterans who receive such services, members of the families of such veterans, and other individuals in close relationships with such veterans.

(B) Personnel of the Department responsible for furnishing such services under the project.

(C) Personnel of non-Department facilities responsible for furnishing such services under the project.

(4) A description and summary of the means of furnishing hospice care services at or through each medical facility of the Department designated under section 1763(a) of this title.

(5) With respect to each such means, the information referred to in paragraphs (2) and (3).

(6) A comparative analysis by the Under Secretary for Health of the services furnished to terminally ill veterans under the various demonstration projects referred to in section 1762 of this title and at or through the designated facilities referred to in section 1763 of this title, with an emphasis in such analysis on a comparison relating to—

(A) the management of pain and health symptoms of terminally ill veterans by such projects and facilities;

(B) the number of inpatient admissions of such veterans and the length of inpatient stays for such admissions under such projects and facilities;

(C) the number and type of medical procedures employed with respect to such veterans by such projects and facilities; and

(D) the effectiveness of such projects and facilities in providing care to such veterans at the homes of such veterans or in nursing homes.

(7) An assessment by the Under Secretary for Health of the desirability of furnishing hospice care services by various means to terminally ill veterans, including an assessment by the Director of the optimal means of furnishing such services to such veterans.

(8) Any recommendations for additional legislation regarding the furnishing of care to terminally ill veterans that the Secretary considers appropriate.

* * * * * * *

PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

CHAPTER 73—VETERANS HEALTH ADMINISTRATION—ORGANIZATION AND FUNCTIONS

* * * * * * *

Subchapter II—General Authority and Administration

§ 7319. Mental illness research, education, and clinical centers

(a) The purpose of this section is to improve the provision of health-care services and related counseling services to eligible veterans suffering from mental illness, especially mental illness related to service-related conditions, through research (including research on improving mental health service facilities of the Department and on improving the delivery of mental health services by the Department), education and training of personnel, and the development of

improved models and systems for the furnishing of mental health services by the Department.

(b)(1) In order to carry out the purpose of this section, the Secretary, upon the recommendation of the Under Secretary for Health and pursuant to the provisions of this subsection, shall—

(A) designate not more than five health-care facilities of the Department as the locations for a center of research on mental health services, on the use by the Department of specific models for furnishing such services, on education and training, and on the development and implementation of innovative clinical activities and systems of care with respect to the delivery of such services by the Department; and

(B) subject to the appropriation of funds for such purpose, establish and operate such centers at such locations in accordance with this section.

(2) The Secretary shall designate at least one facility under paragraph (1) not later than January 1, 1997.

(3) The Secretary shall, upon the recommendation of the Under Secretary for Health, ensure that the facilities designated for centers under paragraph (1) are located in various geographic regions.

(4) The Secretary may not designate any health-care facility as a location for a center under paragraph (1) unless—

(A) the peer review panel established under paragraph (5) has determined under that paragraph that the proposal submitted by such facility as a location for a new center under this subsection is among those proposals which have met the highest competitive standards of scientific and clinical merit; and

(B) the Secretary, upon the recommendation of the Under Secretary for Health, determines that the facility has developed (or may reasonably be anticipated to develop)—

(i) an arrangement with an accredited medical school which provides education and training in psychiatry and with which the facility is affiliated under which arrangement residents receive education and training in psychiatry through regular rotation through the facility so as to provide such residents with training in the diagnosis and treatment of mental illness;

(ii) an arrangement with an accredited graduate program of psychology under which arrangement students receive education and training in clinical, counseling, or professional psychology through regular rotation through the facility so as to provide such students with training in the diagnosis and treatment of mental illness;

(iii) an arrangement under which nursing, social work, counseling, or allied health personnel receive training and education in mental health care through regular rotation through the facility;

(iv) the ability to attract scientists who have demonstrated creativity and achievement in research—

(I) into the evaluation of innovative approaches to the design of mental health services; or

(II) into the causes, prevention, and treatment of mental illness;

(v) a policymaking advisory committee composed of appropriate mental health-care and research personnel of the facility and of the affiliated school or schools to advise the directors of the facility and the center on policy matters pertaining to the activities of the center during the period of the operation of the center; and

(vi) the capability to evaluate effectively the activities of the center, including the evaluation of specific efforts to improve the quality and effectiveness of mental health services provided by the Department at or through individual facilities.

(5)(A) In order to provide advice to assist the Under Secretary for Health and the Secretary to carry out their responsibilities under this section, the official within the Central Office of the Veterans Health Administration responsible for mental health and behavioral sciences matters shall establish a panel to assess the scientific and clinical merit of proposals that are submitted to the Secretary for the establishment of new centers under this subsection.

(B) The membership of the panel shall consist of experts in the fields of mental health research, education and training, and clinical care. Members of the panel shall serve as consultants to the Department for a period of no longer than six months.

(C) The panel shall review each proposal submitted to the panel by the official referred to in subparagraph (A) and shall submit its views on the relative scientific and clinical merit of each such proposal to that official.

(D) The panel shall not be subject to the provisions of the Federal Advisory Committee Act (5 U.S.C. App.).

(c) Clinical and scientific investigation activities at each center established under subsection (b)(1) may compete for the award of funding from amounts appropriated for the Department of Veterans Affairs medical and prosthetics research account and shall receive priority in the award of funding from such account insofar as funds are awarded to projects and activities relating to mental illness.

(d) The Under Secretary for Health shall ensure that at least three centers designated under subsection (b)(1)(A) emphasize research into means of improving the quality of care for veterans suffering from mental illness through the development of community-based alternatives to institutional treatment for such illness.

(e) The Under Secretary for Health shall ensure that useful information produced by the research, education and training, and clinical activities of the centers established under subsection (b)(1) is disseminated throughout the Veterans Health Administration through publications and through programs of continuing medical and related education provided through regional medical education centers under subchapter VI of chapter 74 of this title and through other means.

(f) The official within the Central Office of the Veterans Health Administration responsible for mental health and behavioral sciences matters shall be responsible for supervising the operation of the centers established pursuant to subsection (b)(1).

(g)(1) There are authorized to be appropriated for the Department of Veterans Affairs for the basic support of the research and edu-

cation and training activities of the centers established pursuant to subsection (b)(1) the following:

(A) $3,125,000 for fiscal year 1997.

(B) $6,250,000 for each of fiscal years 1998 through 2000.

(2) In addition to the funds available under the authorization of appropriations in paragraph (1), the Under Secretary for Health shall allocate to such centers from other funds appropriated generally for the Department of Veterans Affairs medical care account and the Department of Veterans Affairs medical and prosthetics research account such amounts as the Under Secretary for Health determines appropriate in order to carry out the purposes of this section.

* * * * * * *

Subchapter IV—Research Corporations

§ 7361. Authority to establish; status

(a) * * *

(b) If by the end of the four-year period beginning on the date of the establishment of a corporation under this subchapter the corporation is not recognized as an entity the income of which is exempt from taxation under [section 501(c)(3) of] the Internal Revenue Code of 1986, the Secretary shall dissolve the corporation.

* * * * * * *

§ 7363. Board of directors; executive director

(a) * * *

* * * * * * *

(c) An individual appointed under subsection (a)(2) to the board of directors of a corporation established under this subchapter may not be affiliated with, employed by, or have any other financial relationship with any entity that is a source of funding for research by the Department unless that source of funding is a governmental entity or an entity the income of which is exempt from taxation under [section 501(c)(3) of] the Internal Revenue Code of 1986.

* * * * * * *

§ 7366. Accountability and oversight

(a)(1)(A) * * *

* * * * * * *

[(d) The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives an annual report on the number and location of corporations established and the amount of the contributions made to each such corporation.]

(d) The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an annual report on the corporations established under this subchapter. The report shall set forth the following information:

(1) The location of each corporation.

(2) The amount received by each corporation during the previous year, including—

(A) the total amount received;

(B) the amount received from governmental entities;

(C) the amount received from entities the income of which is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986 (26 U.S.C. 501(c)(3));

(D) the amount received from all other sources; and

(E) if the amount received from a source referred to in subparagraph (D) exceeded $25,000, information that identifies the source.

(3) The amount expended by each corporation during the year, including—

(A) the amount expended for salary for research staff and for salary for support staff;

(B) the amount expended for other direct support of research; and

(C) if the amount expended with respect to any source exceeded $10,000, information that identifies the source.

* * * * * * *

§ 7368. Expiration of authority

No corporation may be established under this subchapter after [December 31, 1992] *December 31, 2000.*

CHAPTER 74—VETERANS HEALTH ADMINISTRATION—PERSONNEL

Subchapter I—Appointments

* * * * * * *

§ 7406. Residencies and internships

(a)(1) * * *

* * * * * * *

(c)(1) * * *

* * * * * * *

(2) The Secretary may pay to such designated agency, without regard to any other law or regulation governing the expenditure of Government moneys either in advance or in arrears, an amount to cover the cost for the period such intern or resident serves in a [Department hospital] *Department facility furnishing hospital care or medical services of—*

(A) * * *

(B) hospitalization, medical care, and life insurance and any other employee benefits as are agreed upon by the participating institutions for the period that such intern or resident serves in a [Department hospital] *Department facility;*

* * * * * * *

(3)(A) * * *

(B) Notwithstanding subparagraph (A), any period of service of any such intern or resident in a [Department hospital] *Department facility furnishing hospital care or medical services* shall be deemed creditable service for the purposes of section 8332 of title 5.

(4) The agreement with such central administrative agency may further provide that the designated central administrative agency shall—

(A) * * *

* * * * * * *

(C) maintain all records pertinent to the leave accrued by such intern and resident for the period during which such recipient serves in a [participating hospital, including a Department hospital] *participating facility, including a Department facility.*

(5) Leave described in paragraph (4)(C) may be pooled, and the intern or resident may be afforded leave by the [hospital] *facility* in which such person is serving at the time the leave is to be used to the extent of such person's total accumulated leave, whether or not earned at the [hospital] *facility* in which such person is serving at the time the leave is to be afforded.

* * * * * * *

Subchapter II—Collective Bargaining and Personnel Administration

§ 7423. Personnel administration: full-time employees

(a) * * *

(b) A person covered by subsection (a) may not do any of the following:

[(1) Assume responsibility for the medical care of any patient other than a patient admitted for treatment at a Department facility, except in those cases where the person, upon request and with the approval of the Under Secretary for Health, assumes such responsibilities to assist communities or medical practice groups to meet medical needs which would not otherwise be available for a period not to exceed 180 calendar days, which may be extended by the Under Secretary for Health for additional periods not to exceed 180 calendar days each.]

[(2)] *(1)* Teach or provide consultative services at any affiliated institution if such teaching or consultation will, because of its nature or duration, conflict with such person's responsibilities under this title.

[(3)] *(2)* Accept payment under any insurance or assistance program established under title XVIII or XIX of the Social Security Act or under chapter 55 of title 10 for professional services rendered by such person while carrying out such person's responsibilities under this title.

[(4)] *(3)* Accept from any source, with respect to any travel performed by such person in the course of carrying out such person's responsibilities under this title, any payment or per diem for such travel, other than as provided for in section 4111 of title 5.

[(5)] *(4)* Request or permit any individual or organization to pay, on such person's behalf for insurance insuring such person against malpractice claims arising in the course of carrying out such person's responsibilities under this title or for such person's dues or similar fees for membership in medical or dental

societies or related professional associations, except where such payments constitute a part of such person's remuneration for the performance of professional responsibilities permitted under this section, other than those carried out under this title.

[(6)] *(5)* Perform, in the course of carrying out such person's responsibilities under this title, professional services for the purpose of generating money for any fund or account which is maintained by an affiliated institution for the benefit of such institution, or for such person's personal benefit, or both.

(c) In the case of any fund or account described in [subsection (b)(6)] *subsection (b)(5)* that was established before September 1, 1973—

(1) * * *

* * * * * * *

Subchapter III—Special Pay for Physicians and Dentists

SEC. 7432. SPECIAL PAY: WRITTEN AGREEMENTS.

(a) * * *

(b)(1) * * *

(2)*(A)* The Secretary may waive (in whole or in part) the requirement for a refund under paragraph (1) in any case if the Secretary determines (in accordance with regulations prescribed under section 7431(a) of this title) that the failure to complete such period of service is the result of circumstances beyond the control of the physician or dentist.

(B) The Secretary may suspend the applicability of an agreement under this subchapter in the case of a physician or dentist who enters a residency training program for the period of the participation of the physician or dentist, as the case may be, in the program. The physician or dentist shall not be subject to the refund requirements with respect to the agreement under paragraph (1) during the period of the suspension.

* * * * * * *

PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY; ENHANCED-USE LEASES OF REAL PROPERTY

* * * * * * *

Subchapter IV—Sharing of Medical Facilities, Equipment, and Information

8151. * * *

* * * * * * *

8153. [Specialized medical resources.] *Sharing of health-care resources.*

* * * * * * *

Subchapter I—Acquisition and Operation of Medical Facilities

* * * * * * *

§ 8110. Operation of medical facilities

(a)(1) * * *

* * * * * * *

[(c)(1) Notwithstanding any other provision of law but except as provided in paragraph (3) of this subsection—

[(A) a contract may not be entered into as a result of which an activity at a health-care facility over which the Secretary has direct jurisdiction (hereinafter in this subsection referred to as a "Department health-care facility") would be converted from an activity performed by Federal employees to an activity performed by employees of a contractor of the Government unless the Under Secretary for Health has determined that such activity is not a direct patient care activity or an activity incident to direct patient care; and

[(B) in the case of an activity determined by the Under Secretary for Health under clause (A) of this paragraph to be neither such activity, the Secretary, after considering the advice of the Under Secretary for Health and the results of a study described in paragraph (4) of this subsection, may, in the exercise of the Secretary's sole discretion but subject to paragraph (2) of this subsection, enter into a contract as a result of which the activity would be converted from an activity performed by Federal employees to an activity performed by employees of a contractor of the Government.

[(2) The Secretary may enter into a contract under the circumstances described in paragraph (1)(B) of this subsection only if responsive bids are received from at least two responsible, financially autonomous bidders and the Secretary determines—

[(A) based on the study described in paragraph (4) of this subsection with respect to the activity involved, that the cost to the Government of the performance of such activity under such a contract over the first five years of such performance (including the cost to the Government of conducting the study) would be lower by 15 percent or more than the cost of performance of such activity by Federal employees; and

[(B) that the quantity and quality of health-care services provided to eligible veterans by the Department at the facility at which the activity is carried out would be maintained or enhanced as a result of such a contract.

[(3) The provisions of paragraph (1) of this subsection do not apply—

[(A) to a contract or agreement under chapter 17 or section 8111, 8111A, or 8153 of this title or under section 1535 of title 31; or

[(B) to a contract under section 513 or 7409 of this title if the Under Secretary for Health determines that such contract is necessary in order to provide services to eligible veterans at a Department health-care facility that could not otherwise be provided at such facility.

[(4) A study referred to in paragraph (1)(B) of this subsection is a study that—

[(A) compares the cost of performing an activity at a Department health-care facility through Federal employees with the cost of performing such activity through a contractor of the Government;

[(B) is based on an estimate of the most efficient and cost-effective organization for the effective performance of the activity by Federal employees;

[(C) with respect to the costs of performance of such activity through Federal employees, is based (to the maximum extent feasible) on actual cost factors of the Department for pay and retirement and other fringe benefits for the Federal employees who perform the activity; and

[(D) takes into account (i) the costs to the Government (including severance pay) that would result from the separation of employees whose Federal employment may be terminated as a result of the Secretary entering into a contract described in paragraph (1)(B) of this subsection, and (ii) all costs to the Government associated with the contracting process.

[(5) Prior to conducting a study described in paragraph (4) of this subsection, the Secretary shall (in a timely manner) submit to the appropriate committees of the Congress written notice of a decision to study the activity involved for possible performance by a contractor.

[(6) If, after completion of a study described in paragraph (4) of this subsection, a decision is made to convert performance of the activity involved to contractor performance, the Secretary shall promptly submit to the appropriate committees of the Congress written notice of such decision and a report with respect to such conversion. Each such report shall include—

[(A) a summary of the study described in paragraph (4) of this subsection with respect to such contract;

[(B) a certification that the study itself is available to such committees and that the results of the study meet the requirements of paragraph (2)(A) of this subsection;

[(C) a certification that the requirements of paragraph (2)(B) of this subsection would be met with respect to such contract and a summary of the information that supports such certification;

[(D) if more than 25 jobs are affected, information showing the potential economic impact on the Federal employees affected and the potential economic impact on the local community and the Government of contracting for performance of such activity; and

[(E) information showing the amount of the bid accepted for a contract for the performance of the activity and the cost of performance of such activity by Federal employees, together with the total estimated cost which the Government will incur because of the contract.

[(7) Paragraphs (1) through (6) shall not be in effect during fiscal years 1995 through 1999.

[(8) During the period covered by paragraph (7), whenever an activity at a Department health-care facility is converted from per-

formance by Federal employees to performance by employees of a contractor of the Government, the Secretary shall—

[(A) require in the contract for the performance of such activity that the contractor, in hiring employees for the performance of the contract, give priority to former employees of the Department who have been displaced by the award of the contract; and

[(B) provide to such former employees of the Department all possible assistance in obtaining other Federal employment or entrance into job training and retraining programs.

[(9) The Secretary shall include in the Secretary's annual report to Congress under section 529 of this title, for each fiscal year covered by paragraph (7), a report on the use during the year covered by the report of contracting-out authority made available by reason of paragraph (7). The Secretary shall include in each such report a description of each use of such authority, together with the rationale for the use of such authority and the effect of the use of such authority on patient care and on employees of the Department.]

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Subchapter III—State Home Facilities for Furnishing Domiciliary, Nursing Home, and Hospital Care

§ 8131. Definitions

For the purpose of this subchapter—

(1) * * *

* * * * * * *

(3) The term "construction" means the construction of new domiciliary or nursing home buildings, the expansion, remodeling, or alteration of existing buildings for the provision of domiciliary, nursing home, *adult day health*, or hospital care in State homes, and the provision of initial equipment for any such buildings.

§ 8132. Declaration of purpose

The purpose of this subchapter is to assist the several States to construct State home facilities (or to acquire facilities to be used as State home facilities) for furnishing domiciliary or nursing home care to veterans, and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home, *adult day health*, or hospital care to veterans in State homes.

* * * * * * *

§ 8135. Applications with respect to projects; payments

(a) * * *

(b)(1) * * *

(2) Subject to paragraphs (3) and (5)(C) of this subsection, the Secretary shall accord priority to applications in the following order:

(A) * * *

* * * * * * *

(C) An application from a State which the Secretary determines, in accordance with criteria and procedures specified in regulations which the Secretary shall prescribe, has a greater need for nursing home or domiciliary beds or *adult day health care facilities* than other States from which applications are received.

(D) * * *

(3) In according priorities to projects under paragraph (2) of this subsection, the Secretary—

(A) shall accord priority only to projects which would involve construction or acquisition of either nursing home or domiciliary buildings *or construction (other than new construction) of adult day health care buildings;* and

* * * * * * *

Subchapter IV—Sharing of Medical Facilities, Equipment, and Information

§ 8151. Statement of congressional purpose

[It is the purpose of this subchapter to improve the quality of hospital care and other medical service provided veterans under this title, by authorizing the Secretary to enter into agreements with medical schools, health-care facilities, and research centers throughout the country in order to receive from and share with such medical schools, health-care facilities, and research centers the most advanced medical techniques and information, as well as certain specialized medical resources which otherwise might not be feasibly available or to effectively utilize other medical resources with the surrounding medical community, without diminution of services to veterans. Among other things, it is intended, by these means, to strengthen the medical programs at those Department hospitals which are located in small cities or rural areas and thus are remote from major medical centers. It is further the purpose of this subchapter to improve the provision of care to veterans under this title by authorizing the Secretary to enter into agreements with State veterans facilities for the sharing of health-care resources.] *It is the purpose of this subchapter to improve the quality of health care provided veterans under this title by authorizing the Secretary to enter into agreements with health-care providers in order to share health-care resources with, and receive health-care resources from, such providers while ensuring no diminution of services to veterans. Among other things, it is intended by these means to strengthen the medical programs at Department facilities located in small cities or rural areas which facilities are remote from major medical centers.*

§ 8152. Definitions

For the purposes of this subchapter—

[(1) The term "research center" means an institution (or part of an institution), the primary function of which is research, training of specialists, and demonstrations and which, in connection therewith, provides specialized, high quality diagnostic and treatment services for inpatients and outpatients.

[(2) The term "specialized medical resources" means medical resources (whether equipment, space, or personnel) which, because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to maximum utilization only through mutual use.

[(3) The term "health-care resource" includes hospital care, medical services, and rehabilitative services, as those terms are defined in paragraphs (5), (6), and (8), respectively, of section 1701 of this title, any other health-care service, and any health-care support or administrative resource.]

(1) The term "health-care resource" includes hospital care (as that term is defined in section 1701(5) of this title), any other health-care service, and any health-care support or administrative resource.

(2) The term "health-care providers" includes health-care plans and insurers and any organizations, institutions, or other entities or individuals that furnish health-care resources.

[(4)] *(3)* The term "hospital", unless otherwise specified, includes any Federal, State, local, or other public or private hospital.

§ 8153. [Specialized medical resources] *Sharing of health-care resources*

[(a)(1) To secure certain specialized medical resources which otherwise might not be feasibly available, or to effectively utilize certain other medical resources, the Secretary may, when the Secretary determines it to be in the best interest of the prevailing standards of the Department medical care program, make arrangements, by contract or other form of agreement for the mutual use, or exchange of use, of—

[(A) specialized medical resources between Department health-care facilities and other health-care facilities (including organ banks, blood banks, or similar institutions), research centers, or medical schools; and

[(B) health-care resources between Department health-care facilities and State home facilities recognized under section 1742(a) of this title.]

(a)(1) The Secretary, when the Secretary determines it to be necessary in order to secure health-care resources which might not otherwise be feasibly available or to utilize effectively health-care resources, may make arrangements, by contract or other form of agreement, for the mutual use, or exchange of use, of health-care resources between Department health-care facilities and non-Department health-care providers. The Secretary may make such arrangements without regard to any law or regulation relating to competitive procedures.

(2) * * *

* * * * * * *

[(e) The Secretary shall submit to the Congress not more than 60 days after the end of each fiscal year a report on the activities carried out under this section. Each report shall include—

[(1) an appraisal of the effectiveness of the activities authorized in this section and the degree of cooperation from other sources, financial and otherwise; and

[(2) recommendations for the improvement or more effective administration of such activities.]

VETERANS HEALTH CARE ACT OF 1992

* * * * * * *

TITLE II—HEALTH-CARE SHARING AGREEMENTS BETWEEN DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE

* * * * * * *

SEC. 204. EXPIRATION OF AUTHORITY.

The authority to provide services pursuant to agreements entered into under section 201 expires on [October 1, 1996] *December 31, 1998.*

VETERANS' BENEFITS IMPROVEMENTS ACT OF 1994

* * * * * * *

TITLE I—PERSIAN GULF WAR VETERANS

* * * * * * *

SEC. 107. EVALUATION OF HEALTH STATUS OF SPOUSES AND CHILDREN OF PERSIAN GULF WAR VETERANS.

(a) * * *

(b) DURATION OF PROGRAM.—The program shall be carried out during the period beginning on November 1, 1994, and ending on [September 30, 1996] *December 31, 1998.*

○